

MCSIG
COMPLETECARE
(MEDICAL EXPENSE REIMBURSEMENT PLAN)

Effective January 1, 2018

As Amended and Restated
Effective January 1, 2024

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INTRODUCTION

Plan document and summary Plan description. This is the Plan document for the MCSIG Medical Expense Reimbursement Plan (which we will call “CompleteCare” or simply the “Plan”). Because this document is written in plain English, it also serves as the Summary Plan Description for the Plan.

Sponsor and administrator. The Plan is sponsored and administered by MCSIG (which we will call the “Sponsor” or the “Plan Administrator”), whose address is 76 Stephanie Drive, Salinas, CA 93901 and whose employer identification number for federal tax purposes is 77-0320746.

Claims Administrator. Catilize Health is the Claims Administrator for the Plan, whose address is 2605 Nicholson Road, Suite 1140 Sewickley, PA 15143. Their phone number is 1-877-872-4232, their Fax number is 1-877-599-3724. They can also be reached at memberservices@catilizehealth.com.

Ordinary names. Throughout the Plan, we will refer to things by their ordinary name. We will call this Plan simply “the Plan.” When we say “you,” we mean you the employee who participates in this Plan.

Effective date. This Plan was originally effective January 1, 2018. This revision of the Plan takes effect on January 1, 2024. As of that date, it entirely supersedes and replaces all prior Plans, programs and policies (if any) providing benefits of the same type as the benefits set forth in this Plan.

Plan year. You will see references to the “Plan Year” in this document. The “Plan Year” is the 12- month period ending each December 31.

Questions. If you have questions after you read the Plan, ask the Plan Administrator for help. Only the Plan Administrator is authorized to interpret and apply the Plan.

PARTICIPATION

General eligibility rules. This Plan is designed to cover employees who would otherwise be eligible for the MCSIG Health Plan but who choose not to participate in that plan because they have **coverage** available through their spouse/domestic partner’s employer, their parent (non-MCSIG plan), another employer of the employee, or group coverage available to the employee from any other source including but not limited to eligible retiree benefit programs other than Medicare, Tricare or Medicaid (which we will call “Alternate Coverage”). If your Alternate Coverage is a High Deductible Health Plan (HDHP) and you do not have any contributions to an HSA bank account, you may be eligible to enroll in CompleteCare. If the other coverage is a HDHP and your spouse/domestic partner is not enrolled in CompleteCare, your spouse/domestic partner may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in CompleteCare. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by CompleteCare.

Eligibility. You are eligible for this Plan if:

- you are eligible for, and the Sponsor has offered to you (besides this plan), a group health plan that does not consist solely of “excepted benefits” under the Affordable Care Act (“ACA”); and
- you are actually enrolled in a group health plan that is sponsored by an employer; and
- the Alternate Coverage does not consist solely of “excepted benefits” under the ACA and does not consist of just a “health reimbursement arrangement” (HRA).

You are NOT eligible if your Alternate Coverage is through another participating MCSIG medical plan.

Enrollment. To participate in the Plan, you must enroll by completing your Enrollment and Attestation via your online enrollment system (if applicable) or by paper form. If you are completing paper forms, return paper forms as directed on the form. Your enrollment will take effect once you have satisfied the eligibility requirements.

The completed the annual Attestation form must be returned to Catilize Health by January 31st each year. If your Attestation form is not received by this deadline, you will not be eligible to participate in the Plan affected.

It is a condition of participation in this Plan that you provide to the Plan Administrator information about your Alternate Coverage sufficient for the Plan Administrator to assure that the requirements for an “integrated HRA” under Section 9815 of the federal tax code and its implementing regulations are satisfied. In addition, a Social Security number is required for enrollment under the Plan.

If you are currently employed by MCSIG and have opted out of the MCSIG Health Plan, you may be eligible to enroll in CompleteCare during open enrollment each year.

Spouse/domestic partner and dependents. You may enroll your spouse/domestic partner and any eligible dependents in the Plan.

When your participation ends. Your participation in the Plan ordinarily ends on the last day of the month in which you are no longer actively employed by a MCSIG employer participating in the Plan, or if you otherwise cease to meet the eligibility requirements. In addition, you are permitted to permanently opt out of this Plan and waive all future reimbursements from this Plan, annually at open enrollment. Upon termination of employment, you are permitted to permanently opt out of, and waive, all future reimbursements from this Plan (such as reimbursements to which you became entitled while you were participating in this Plan but have not been paid yet).

We say “ordinarily,” because there are several possible exceptions:

- ▶ If you are on a leave to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not be considered to have ceased active employment under the Plan as long as you are on a leave to which you are entitled by the FMLA.
- ▶ If you are absent due to military service, you will be considered on leave of absence and treated the same as any other employee on leave of absence with regard to the Plan unless and until you knowingly give written notice of intent not to return in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994. That means that if the employer extends active coverage under this Plan to employees on non-military leave, your active coverage under this Plan will be similarly extended (assuming you continue to meet the eligibility requirements listed above).

Choices available when participation ends. When participation ends, under some circumstances, you may choose to buy continued coverage under this Plan. This is sometimes known as "COBRA" coverage, and it is explained in Appendix B.

PLAN BENEFITS

In general. This Plan helps you take advantage of your Alternate Coverage by reimbursing you for after-tax employee contributions, eligible co-pays, co-insurance and deductibles under that other coverage. This plan does not reimburse any expenses other than eligible co-payments, co-insurance, deductibles and after-tax premiums under the plan of your Alternate Coverage.

Reimbursement of after-tax employee contributions. This Plan reimburses you for a portion of the premium that you (or your spouse/domestic partner/dependent) pay for the Alternate Coverage. The portion that you are entitled to is shown on a table on Appendix A to this document. Reimbursement of employee contributions is free from federal income tax and FICA if you (or your spouse/domestic partner) have paid the employee contributions for the Alternate Coverage on an *after-tax* basis.

If you (or your spouse/domestic partner) have paid the employee contributions for the Alternate Coverage on a *pre-tax* basis (such as through a cafeteria Plan, sometimes known as a "section 125" Plan), the IRS says that the other employer (not you) has paid the employee contribution, as far as federal tax law is concerned, so reimbursement of employee contributions under this Plan is taxable.

Notice of an increase in Alternate Coverage's premium must be provided to the Sponsor within 31 days of the effective date of the change. If notification of an increase and required documentation is provided within 31 days of the effective date of the change, employee will be reimbursed retroactive to the effective date of the change.

If employee does not notify Sponsor of a premium increase within 31 days as outlined above, then your premium reimbursement will not be adjusted until the 1st day of the month following receipt of the notification and required documentation and will not be retroactive.

Employees are also required to submit the required documentation annually, within 31 days of the Plan year renewal. If the required documentation is not provided to the Employer within 31 days of the Plan year renewal, the premium reimbursements will be suspended.

You must notify Employer immediately if there is a premium decrease. A participant's acceptance of a premium reimbursement in excess of the amount of premiums actually paid for Alternate Coverage shall constitute fraud or intentional misrepresentation.

Reimbursement of eligible co-pays, co-insurance and deductibles. This Plan reimburses you for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage each Plan year, up to the annual ACA maximum.

Reimbursement of Over-the-Counter Drugs. The Plan will not reimburse you for over-the-counter drugs unless they are prescribed by your physician (or the drug is insulin).

Obtaining Reimbursement

CompleteCare ID Card – For doctor’s office visits, pharmacies, labs, hospitals, etc., please present your Alternate Coverage ID card first (i.e. your spouse/domestic partner’s health insurance), then present the CompleteCare ID card. If your Alternate Coverage requires a co-pay, co-insurance or deductible, you will not be required to pay that at the time of the visit in most cases. By presenting the CompleteCare ID Card, the provider may bill the Claims Administrator directly. If you need to print a CompleteCare ID Card, you can do so at portal.catilize.com.

If your provider does not accept the CompleteCare ID Card, you may still use that provider; however, you will be required to file a paper claim or submit the claim electronically.

Paper Claims - To claim reimbursement under the Plan with a paper claim, complete a claim form, available from the Plan Administrator or Claims Administrator, and return it to the Claims Administrator for the Plan at the address shown on the form. A check with your reimbursement will be mailed to you as soon as possible after the claim is approved.

Electronic Claims - To claim reimbursement under the Plan electronically, go to portal.catilize.com and submit the required documentation. A check with your reimbursement will be mailed to you as soon as possible after the claim is approved.

Funding. Reimbursements under the Plan are paid from the general assets of the employer. They are not funded or insured in any way.

ADMINISTRATION, CLAIMS AND APPEALS

Administration. The Plan Administrator has all rights, duties and powers necessary or appropriate for the administration of the Plan, except to the extent that they are vested in a separate claims authority (as described in this section) or in the appeals authority (as described in the following section).

All of the deadlines for decisions by the Plan Administrator or other decision maker are deadlines which you have a right to insist upon. But nothing in these rules prevents you from giving up that right and voluntarily agreeing to an extension of any deadline for the Plan Administrator or other decision maker.

Notification in writing includes any form of writing. For example, this may include a printed form, a letter, a fax or an e-mail. By contrast, oral notification means notification by means of the spoken voice, either in person or through some other medium such as the telephone.

Claims. Claims should be addressed to the third-party Claims Administrator as follows:

Claims Administrator Catilize Health 2605 Nicholson Road Suite 1140 Sewickley, PA 15143 1-877-872-4232 Phone 1-877-599-3724 – Fax complecare@catilizehealth.com

If the Claims Administrator has any special rules for filing and processing claims, they are described in the written materials that are available from the Claims Administrator, and you should follow them. But the rules of the Claims Administrator must in any event satisfy the minimum standards described in the balance of this section.

You must submit your claims as soon as possible, but no later than 90 days after plan year ends or 90 days after termination. Providers must submit your claims no later than 1 year from date of service. If you fail to submit your claim by the deadline, you are not entitled to reimbursement and your claim will be denied. Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited if not claimed (or cashed) within twelve (12) months after the check is issued.

Denial of claims. If your claim is denied, the Claims Administrator will respond to you in writing within a reasonable period of time, but always within 30 days. As an exception, the Plan may take an additional 15 days (for a total of 45) as long as the decision maker concludes that an extension is necessary for reasons outside the control of the decision maker and notifies you, before the original 30 days expire, about why an extension is necessary and when a decision is expected. If the reason for the extension is that you have not provided all of the information necessary to decide on your claim, then the original 30-day clock will stop, beginning on the date when you are sent notification of the extension, until you provide the information.

The written notice will point out the specific reasons and Plan provisions on which the denial is based, describe any additional information needed to complete the claim, and describe the appeal procedure, including time limits for submitting your appeal.

In addition, the notice will include the following information:

- If the Plan provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.
- If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be offered a copy, upon request and free of charge. Alternatively, the decision maker may simply include a copy with your notification.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist you.
- The decision on the claim will also be sure to include information sufficient to identify the claim, including, as applicable, the date of service, the health care provider, the claim amount, a statement describing the availability (upon request) of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the denial code and its corresponding meaning.

If your claim is denied and you disagree and want to pursue the matter, you *must* file an appeal in accordance with the following procedures. You *cannot* take any other steps unless and until you have exhausted the appeal procedure. For example, if your claim is denied and you do not use the appeal procedure, the denial of your claim is conclusive and *cannot be challenged, even in court.*

“Rescission” appeals. If your coverage under the plan is “rescinded,” meaning that it is cancelled or discontinued with retroactive effect, for any reason other than your failure to pay employee contributions or premiums, that is considered a denial of benefits that triggers a right to appeal.

Appeals. To file an appeal, write to the Executive Director at 76 Stephanie Drive, Salinas, CA 93901 stating the reasons why you disagree with the denial of your claim. You must do this within *180 days after the claim was denied*. You have the right to be represented by anyone else, including a lawyer if you wish.

The appeals authority will never be the same person who denied the claim and will never be subordinate to the person who denied the claim. To assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a member of the appeals committee) will never be based on the likelihood that the individual will support a denial of benefits. The appeals authority will review each appeal without giving any deference to the initial decision that was made on the claim.

Upon request, you will be provided reasonable access to the claim file. You will be provided reasonable access to, and free copies of, all documents, records, and other information that constitute a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for your diagnosis (without regard to whether the decision maker relied on it in making the decision on your claim). And if the decision maker obtained the advice of medical or vocational experts in connection with your claim, you are entitled to know who they are, regardless of whether the decision maker relied on their advice.

If the denial of your claim was based, in any part, on a medical judgment, such as a judgment whether a particular treatment or drug is experimental or medically necessary, the appeals authority will consult with a health care professional who has appropriate training and experience in that field of medicine. This will not be (or be a subordinate of) any health care professional who consulted on the initial denial of your claim.

If you file an appeal, you have the right to submit written comments, documents, records and other information relating to your claim. This may include new information that was not submitted as part of your claim. All such information will be considered in your appeal.

If during the appeal process any new or additional evidence is considered, relied upon, or generated in connection with your claim, it will be provided to you as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. Before the appeals authority can issue an adverse decision based on any new or additional rationale, you will be advised of the rationale as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. While the appeals authority is not required to hold a hearing, you will be entitled to present testimony.

The appeals authority will issue a written decision within 60 days. The decision will explain the reasoning of the appeals authority, will refer to the specific provisions of this Plan on which the decision is based, and will remind you once again of your right of reasonable access to, and copies of, all relevant documents.

If you are not granted all that you seek in filing the appeal, you will be given:

- The specific reasons why.
- Specific references to the provisions of the Plan on which the decision was based. If those provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the Plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.
- If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be offered a copy, upon request and free of charge. Alternatively, the decision maker may simply include a copy with your notification.
- A statement that you are entitled to receive relevant information.
- A description of available internal appeals and any external review process, including information about how to initiate them and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist you.

The decision on the appeal will also be sure to include information sufficient to identify the claim, including, where applicable, the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and (if the decision is adverse) the denial code and its corresponding meaning.

Exhaustion. If the Plan fails to adhere to the claim and appeal procedures described above in this section, you *may* be excused from exhausting them and proceed directly to an external appeal (described below) or to a lawsuit. But you are *not* excused from exhausting the regular claim and appeal procedures if the failure is *de minimis* (a legal term that basically means "insignificant") and does not cause (and is not likely to cause) prejudice or harm to you, as long as the Plan demonstrates that the failure was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the plan.

The exception for *de minimis* failures is not available if the violation is part of a pattern or practice of violations by the plan. You may request a written explanation of the failure from the Plan, in which case the Plan will provide an explanation within 10 days, including a specific description of its basis, if any, for asserting that the failure should not cause the internal claims and appeals process to be considered exhausted.

If you think that exhaustion is excused under this section and proceed directly to external review or a lawsuit, but it turns out that exhaustion was *not* excused after all, you will have the right to resubmit and pursue the internal appeal of the claim. If that happens, then within 10 days after the external reviewer or court rejects your claim of exhaustion, the Plan will notify you of the opportunity to resubmit and pursue the internal appeal of the claim. Any deadlines for filing a claim will then begin to run when you get that notice.

External review. External review is available for adverse benefit determinations relating to medical

care that involve either medical judgment or rescission of coverage. This includes, but is not limited to, judgment as to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational. This does not include determinations that you are not eligible for the plan.

How. You file a written request for an external review with the Plan Administrator.

When. You file it within four months after receiving an adverse decision on your appeal. If you are excused from filing an appeal, you file the request for external review within four months after receiving an adverse decision on your claim. (Where there is no date corresponding to four months after receipt of the adverse determination, the deadline is the first day of the fifth month thereafter.)

Preliminary screening. Your request will be screened within five days to be sure that your request is appropriate for external review. The Plan Administrator will verify that your claim does not relate to eligibility for the Plan, that you were in fact covered at the appropriate time, that you have exhausted the appeal process (or are excused from exhausting it), and that you have provided all the needed information.

One day after the screening is complete, you will be notified whether your request for external review has been accepted or, if it has not been accepted, why it was not. If the screening shows that you were not eligible for the Plan at the appropriate time, the reasons will be provided. If the screening shows that the request is incomplete, you will be told exactly what more is required, which you can provide within the original four-month period (or within 48 hours after receiving the screening notice, if later).

Referral to independent review organization. If accepted, your request for external review will be forwarded to an independent review organization (which we will call the “IRO”). External appeals will be rotated among the IRO’s with whom the plan has contracted.

Exchanges of information. Within five business days, the Plan Administrator will provide the IRO with all information that was considered in making the adverse determination. The IRO will also notify you of your opportunity to submit additional information for the IRO to consider (which it will then provide to Plan Administrator, so that the Plan may reconsider its decision in light of any new information).

Reversal by the Plan. If the Plan decides to reverse the denial and provide the benefit, it will notify you and the IRO within one business day. The external review will thereupon be terminated.

Consideration by the IRO. The IRO will consider all the information received and render its decision within 45 days after it was first engaged. It will issue a written decision to you and to the Plan that includes all of the information required by the Affordable Care Act.

Retention of records. The IRO will thereafter retain its records of your external review for six years, during which time it will make the records available for examination by you, the Plan, or any state or federal oversight agency (except where disclosure would violate some privacy law).

Compliance. If the IRO reverses the adverse determination, the Plan will immediately provide payment for your claim, without regard to whether the Plan intends to seek judicial review of the decision of the IRO, unless and until there is a judicial decision otherwise.

CHANGING OR ENDING THE PLAN

Changing the Plan. The Sponsor has the right to change the Plan in any way and at any time and is not required to give a reason for the changes. These changes can be retroactive. All changes to the Plan must be in writing. Any special arrangement made by the Sponsor for an individual will constitute an amendment to this Plan applicable only to that individual.

Ending the Plan. The Plan has no set expiration date; when it was established, it was not intended to be temporary. Nevertheless, the Sponsor has the right to end the Plan (in whole or in part) at any time and is not required to give a reason for doing so.

MISCELLANEOUS

Subrogation. If the Plan reimburses you for medical or other expenses under this Plan (relating to you or anyone else deriving coverage through you, such as a spouse/domestic partner or child) but later you recover some or all of those expenses from a third party, you are required to repay the Plan to that extent. This could happen, for example, if you are in an automobile accident, where the Plan pays for hospital care but later you make a claim against the other driver and recover for those same hospital expenses. For additional examples, it could also happen where some other person is responsible under contract or tort law for illness, injury, disease or some other condition suffered by you or anyone else deriving their coverage through you, such as medical error or malpractice where you are compensated by reduction in the cost of a medical procedure.

By reimbursing you for medical or other expenses (either directly or through insurance), the Plan automatically acquires an equitable lien against any and all recovery that you get from a third party, and *you are required to (and automatically agree to) hold and account for any such recovery separately from your general assets, in constructive trust for the benefit of the Plan, so that the Plan's right of recovery is unimpaired under the rules of equity.* You agree not to take any action that could prejudice the Plan's right of recovery. The so-called "make whole" rule does not apply except to the extent that the Plan Administrator in its discretion chooses to apply it. Likewise, the "common fund" rule does not apply except to the extent that the Plan Administrator in its discretion chooses to apply it.

The Plan Administrator has discretion to enforce this provision by any necessary or appropriate means, which might include (a) withholding payment under the Plan until the outcome of your claim against the third party is known, (b) making payment under the Plan but requiring you to sign a form pledging to repay the Plan to the extent of any recovery from a third party, (c) making payment under the Plan but relying on this provision of the Plan to establish your obligation to repay, (d) intervening in your action against the third party in order to protect the rights of the Plan, (e) taking legal action against you for repayment, and (f) setting off your obligation to repay against future benefits otherwise due under the Plan.

Qualified medical child support orders. If the Plan Administrator receives a child support order that is (i) a judgment, decree or order of a court (including approval of a settlement agreement) (or else issued through an administrative process established under state law that has the force and effect of law under applicable state law), that (ii) provides for child support for a child of an eligible employee and (iii) either relates to benefits under the Plan or enforces a federally prescribed state law relating to Medicaid recipients, then the Plan Administrator will notify you and the child that the order has been received and describe the procedure that the Plan Administrator will follow in deciding whether to honor the order.

Next, the Plan Administrator will separately account for health care claims filed that, in the absence of the order, would not be paid. Payment of these claims will be neither approved nor denied while the Plan Administrator decides whether to honor the order.

The Plan will *not* honor a child support order unless it constitutes a “qualified medical child support order” under the law. That means the Plan will not honor a child support order unless it specifies:

- that it applies to this Plan;
- the name and last known mailing address of the affected employee;
- the name and last known mailing address of the child;
- a reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the coverage is to be determined; and
- the time period to which the order applies.

Also, the Plan will *not* honor a child support order that purports to require the Plan to provide any type or form of benefit, or any option, that is not already provided for in the Plan (except as necessary to satisfy a federally prescribed state law relating to Medicaid recipients). Upon making the decision whether the order is a “qualified medical child support order” under the law, the Plan Administrator will notify the employee and the child and act in accordance with the decision. Whichever way the decision goes, the decision will be considered a denial of benefits subject to the appeal procedure described earlier in the Plan under the heading “Appeals.”

Family and Medical Leave. While on a leave of absence to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not suffer the loss of any “employment benefit” (as defined for the purpose of the Family and Medical Leave Act) under the Plan which had accrued before you took the leave and which would not have been lost if you had remained actively at work. But you will not accrue any additional “employment benefits” under the Plan during the leave, except as specifically set forth in the Plan.

Military service. Upon re-employment in accordance with the federal Uniformed Services Employment and Reemployment Act of 1994 (which has rules about honorable discharge and time limits on returning to work), you regain entitlement to all rights and benefits *which are determined by length of service* that you had under the Plan when the military service began, plus any additional such rights and benefits that you would have accrued if you had remained continuously employed during the military service.

In addition, no exclusion or waiting period will be applied under the Plan that would not have been applied if you had remained continuously employed, except with respect to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Legal nature of this Plan. This Plan is an integrated health reimbursement arrangement under Section 9815 of the Internal Revenue Code and, in case of any doubt or question, shall be interpreted in accordance with that Section and its implementing regulations.

Fail-safe provisions for compliance with ACA. Though we believe that the ordinary terms of the Plan, which are set out in this document, fully comply with the Affordable Care Act of 2010 (“ACA”), we

want to be sure there is no misunderstanding. And so we recite here that the following provisions apply with respect to the Plan:

Lifetime limits. Effective with the first Plan year beginning on or after September 23, 2010, there will be no lifetime limit on the dollar value of benefits, with the exceptions provided by the ACA and regulations issued under it.

Restriction on rescission. Effective with the first Plan Year beginning on or after September 23, 2010, your coverage cannot be cancelled or discontinued with retroactive effect except in case of fraud or intentional misrepresentation of a material fact and, even then, not before 30 days of advance written notice have been provided to each participant who would be affected by the rescission.

Fail-safe provisions for compliance with HIPAA. Though we believe that the ordinary terms of the Plan, which are set out in this document, fully comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we want to be sure there is no misunderstanding. And so we recite here that, effective with the first Plan year beginning on or after July 1, 1997:

Access. The Plan will not exclude an employee, nor impose a longer waiting period to get into the Plan, nor require any individual to pay a premium or contribution that is greater than the premium or contribution for “a similarly situated individual” on the basis of health status, medical condition (whether physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including “conditions arising out of acts of domestic violence”), or disability, disregarding premium discounts or rebates or modification of co-payments or deductibles in return for adherence to programs of health promotion and disease prevention-all within the meaning of HIPAA.

Portability. This Plan does not impose a pre-existing condition limitation.

Maternity. Effective with the first Plan Year beginning on or after January 1, 1998, the Plan will comply with the Newborns’ and Mothers’ Health Protection Act of 1996. In that regard, government regulations also require us to provide this statement, effective on the same date, drafted by the federal government:

“Under federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Mental health parity. Any feature of the Plan that constitutes a "group health Plan" under the law will comply with the Mental Health Parity and Addiction Equity Act of 2008 if two conditions are met: (1)

the employer has 50 employees or more and (2) compliance does not raise the cost of health insurance coverage under the Plan by 2% or more for the first year and 1% or more for each successive years, all as determined under the applicable regulation. In addition to treatment for mental health, this law also covers treatment for substance abuse.

Genetic information nondiscrimination. Any feature of the Plan that constitutes a “group health Plan” under the law will comply with the Genetic Nondiscrimination Act of 2008.

Women’s Health and Cancer (WHCRA). If the Plan provides medical and surgical benefits for mastectomy, it must also make available coverage for (a) reconstruction of the breast on which the mastectomy has been performed, (b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications at all stages of mastectomy, including lymph edemas, in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to annual deductibles and coinsurance provisions consistent with other benefits under the Plan.

And the Plan is not permitted to deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the Plan, solely for the purpose of avoiding the requirements of WHCRA. Nor may a group health Plan penalize or otherwise reduce or limit the reimbursement of an attending physician (or other provider) or provide incentives (monetary or otherwise) to induce the physician to provide care in a manner inconsistent with WHCRA. But nothing in WHCRA prevents a group health Plan from negotiating with a physician the level and type of reimbursement for care provided in accordance with the new law.

Correction of errors. If at any time it is determined that a mistake has been made with regard to administration of the Plan, regardless of whether the mistake is favorable or detrimental to you, your spouse/domestic partner, or your dependent, all feasible steps will be taken as soon as reasonably possible to correct the mistake by returning you, your spouse/domestic partner, or your dependents to the position that you would have been in if the mistake had not occurred.

If the mistake is an overpayment of benefits, this provision of the Plan requires (and you agree by acceptance of the benefit) that the overpayment is automatically subject to an equitable lien in favor of the Plan and that the recipient (you, your spouse/domestic partner, your dependent, or the provider) holds the mistaken overpayment in a constructive trust for the benefit of the Plan. You agree that, upon notification of the mistake, the mistaken amount will be segregated from your (or the provider’s) general assets and held separately in order to facilitate restitution to the Plan. You agree to restore any and all mistaken payments to the Plan, or use your best efforts to cause a provider to restore any and all mistaken payments to the Plan, and further that the Plan is entitled to equitable relief under section 502(a)(3) of ERISA.

If you are a participant in the Plan when the demand for restitution is made, the Plan Administrator is authorized (but not required) to enter into an agreement with you under which restitution will be made by applying the amount due against benefits to which you subsequently become entitled under the Plan. If you request, and the Plan Administrator agrees to, this method of restitution, you remain responsible (in accordance with the preceding paragraph) for any and all amounts unrecovered and remaining due when your participation in the Plan ends.

Service of process. Service of legal process may be made on the Plan Administrator.

Administrative Exception: Any administrative exception made to the Plan by the Plan Sponsor will be deemed to be an amendment to the Plan for that individual and that individual only.

APPENDIX A – REIMBURSEMENT LEVELS

COMPLETECARE

Premium Contribution Reimbursement:

You may be reimbursed for the difference between your Alternate Coverage's monthly cost increase and your MCSIG employee contribution, provided your Alternate Coverage's monthly cost is paid on an after-tax basis, up to the following amounts per month:

Employee only	\$100
Employee + Spouse/Domestic Partner	\$200
Employee + Child	\$200
Employee + Children	\$300
Family coverage	\$300

Claims Reimbursement:

You may be reimbursed for eligible co-pays, co-insurance and deductibles up to the ACA limits each Plan year.

Any procedure not covered by the Alternate Coverage will not be covered under this Plan.

APPENDIX B – COBRA CONTINUATION COVERAGE

Introduction. This policy implements the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), as amended to date, with respect to the Plan. In this appendix, the Plan will be referred to interchangeably as either “the Plan” or “the group health Plan.”

Every employee, spouse/domestic partner and dependent covered by the Plan who suffers a qualifying event will be afforded the opportunity to purchase continuation coverage under COBRA in accordance with this policy. Interpretation of this policy will be guided by the intent of the employer to comply fully with COBRA, applicable regulations, and applicable judicial decisions there under but not to provide any rights or benefits in excess of the minimum requirements thereof. This policy overrides the COBRA policies of any third-party administrator.

General COBRA notification. Within 90 days after an employee first becomes covered by the Plan, a copy of this COBRA appendix will be sent by mail to the employee at the employee’s home address. If the employee’s spouse/domestic partner has become covered by the Plan by the time when this notice is sent to the employee, and if the spouse/domestic partner’s home address is the same as the employee’s, the notice will be addressed to the employee and spouse/domestic partner.

If the spouse/domestic partner has not become covered by the Plan by the time when this notice is sent to the employee, or if the spouse/domestic partner’s home address is not the same as the employee’s home address, a separate copy of this COBRA appendix will be sent to the spouse/domestic partner at the spouse/domestic partner’s home address. If the employee is widowed or divorced and then remarries and adds the new spouse/domestic partner to the Plan, a new copy of this notice will be sent to the new spouse/domestic partner.

As an exception, if a qualifying event occurs and the Plan Administrator is required to provide a COBRA election notice (as explained below) before the general COBRA notification is due, the general COBRA notification will be included with the COBRA election notice.

The Plan Administrator will keep proof of mailing of these notices. Alternately, if the Plan Administrator chooses to use electronic transmission of documents (as explained near the end of this appendix), the Plan Administrator will keep a record of the transmission.

Qualifying events. Qualifying events are any of the following *if the event causes a loss of coverage under the Plan*. Even if coverage is not lost entirely, a loss of coverage will nevertheless be considered to occur if the resulting coverage is in any way inferior to, or more expensive to the individual than, that provided to similarly situated individuals who have not suffered a qualifying event.

An event is a qualifying event regardless of whether the loss of coverage occurs at the same time as the event or is delayed, as long as the loss of coverage will occur before the end of the maximum period of COBRA continuation coverage. The qualifying event is considered to occur when the event occurs, regardless of when coverage under the group health Plan is lost. Any extension of coverage at the employer’s expense after such an event will be considered voluntary relief from the COBRA premium requirement rather than a postponement of the qualifying event.

Reduction in hours. Reduction in the employee’s hours for any reason, including, for example, layoff, leave of absence, and reduction from full-time to part-time, is a qualifying event for the employee,

the employee's spouse/domestic partner if covered by the group health Plan at the time of the event, and each dependent child covered by the group health Plan at the time of the event.

Since a leave to which an employee is entitled under the federal Family and Medical Leave Act does *not* result in loss of coverage under any group health Plan, such a leave does not constitute a qualifying event. If the employee fails to return to employment at the end of such a leave, however, the failure to return will cause a loss of coverage and so the failure to return will constitute a qualifying event which occurs at the end of the leave.

Termination of employment. Termination of an employee's employment, whether voluntary or involuntary and including quit and retirement, is a qualifying event for the employee, the employee's spouse/domestic partner if covered by the group health Plan at the time of the event, and each dependent child covered by the group health Plan at the time of the event, except that (a) termination of employment does not constitute a qualifying event with regard to coverage that was previously lost (or continued under COBRA) due to a reduction in hours and (b) termination of employment by reason of gross misconduct of the employee will not constitute a qualifying event for the employee, spouse/domestic partner or dependent children.

Death. Death of the employee is a qualifying event for the employee's spouse/domestic partner if covered by the group health Plan at the time of the event and for each dependent child covered by the group health Plan at the time of the event.

Divorce or legal separation. Divorce from the covered employee is a qualifying event for the employee's spouse/domestic partner if covered by the group health Plan at the time of the event and for each dependent child covered by the group health Plan at the time of the event. This also applies to "legal separation" if such a condition is recognized in your state.

Medicare coverage. The employee's becoming covered by Medicare (that is, actual coverage, not mere eligibility) is a qualifying event for the employee's spouse/domestic partner if covered by the group health Plan at the time of the event and for each dependent child covered by the group health Plan at the time of the event.

Cessation of dependent status. A child's cessation of dependent status (for example, by attaining age 26) is a qualifying event for the dependent child if covered by the group health Plan at the time of the event.

Each person who is entitled to continuation coverage by reason of a qualifying event is referred to from this point forward as a "qualified beneficiary." Only an individual who was actually covered by the group health Plan at the time of the qualifying event can be a qualified beneficiary, with two possible exceptions:

- Any reduction or elimination of coverage that is done in anticipation of the qualifying event will be disregarded. For example, if an employee drops their spouse/domestic partner from coverage in anticipation of the qualifying event, the spouse/domestic partner will still be considered covered at the time of the qualifying event.
- Children born to (or placed for adoption with) the employee during continuation coverage may become qualified beneficiaries as described in more detail below.

Notice of qualifying event from employer to Plan Administrator. The employer will notify the Plan Administrator within 30 days after:

- the termination of employment of the employee (other than by reason of gross misconduct),
- a reduction in the employee's hours that would result in a loss of coverage,
- the death of the employee, or
- the employee's becoming covered by Medicare.

As an exception, if this COBRA appendix provides that the qualifying event will be considered to occur when the employee would otherwise lose coverage, the employer will provide this notice within 30 days after the employee would otherwise lose coverage.

The notice will be sufficient to identify this Plan, the covered employee, the qualifying event, and the date of the qualifying event. There is no requirement about how this notice will be given.

Notice of qualifying event from qualified beneficiary to Plan Administrator. The employee, spouse/domestic partner or affected dependent child (or a representative acting on their behalf) must notify the Plan Administrator of:

- divorce or legal separation of the employee and spouse/domestic partner, or
- the dependent child's ceasing to be a dependent child.

Notice by any one of them will be considered notice on behalf of all of them who are affected.

Except with respect to disability, the notice must be provided no later than 60 days after the event occurs (or coverage would otherwise be lost, if later). Any qualified beneficiary who claims extended continuation coverage by reason of being disabled during the 60 days after the original qualifying event must notify the Plan Administrator of the disability determination *both* within 60 days after receiving the Social Security determination *and* within the original 18-month period of continuation coverage. As an exception, if the Social Security Administration made the determination of disability before the original qualifying event, notice must be given within 60 days after the original qualifying event (or coverage would otherwise have been lost due to the original qualifying event, if later). A qualified beneficiary receiving extended continuation coverage due to disability must notify the Plan Administrator of any final determination that the person is no longer disabled and must do so within 30 days after receiving the determination.

In all cases, as an exception, if the Plan Administrator has not yet provided either the general COBRA notification or notice of a qualifying event, the deadline period will not begin to run until one of those notices has been provided.

Notice by the qualified beneficiary must be made in writing on a form supplied by the Plan Administrator, which must be completed and returned to the Plan Administrator at the address shown on the form, showing at a minimum the Plan, the employee, the qualified beneficiary, the qualifying event (or disability) and the date of the qualifying event (or disability).

Please note: Timely notice by the qualified beneficiary in accordance with this procedure is a condition to entitlement to COBRA continuation coverage (or extended coverage, as the case may be). If the qualified beneficiary does not provide the required notice within the deadlines set forth above, the qualified beneficiary *is not entitled to COBRA continuation coverage (or extended coverage, as the case may be).*

Notice of qualifying event from Plan Administrator to qualified beneficiaries. Within 14 days after receiving notice of a COBRA qualifying event from the employer or the qualified beneficiary (as just described), the Plan Administrator will notify all qualified beneficiaries of their right to elect continuation coverage under COBRA. (Note that, where the employer *is* the Plan Administrator, this affords the Plan Administrator a total of 44 days.)

The notice will identify the Plan; the name, address and telephone number of the person or entity responsible for administering COBRA; the qualifying event; the qualified beneficiaries (by name or by status); the COBRA premium; the date on which coverage will terminate if COBRA continuation coverage is not chosen; the date on which COBRA coverage will begin if chosen; the date on which COBRA coverage will end if chosen; and will include a complete explanation of COBRA continuation coverage (such as by including a copy of this COBRA appendix).

Notice will be given to each qualified beneficiary (employee, spouse/domestic partner, and each dependent child) by mail addressed to the qualified beneficiary at the last known address. As an exception, where qualified beneficiaries include dependent children and the spouse/domestic partner is also a qualified beneficiary, then notice to the spouse/domestic partner will be considered notice to all dependent children who reside with the spouse/domestic partner. For example, where the qualified beneficiaries are the employee, the spouse/domestic partner and one or more dependent children *and they are all living at the same address*, the notice will be sent there addressed to the employee and the spouse/domestic partner.

If the Plan Administrator receives notice from the employer or from the qualified beneficiary (as described above) but decides that the qualified beneficiary is not entitled to COBRA (or an extension of COBRA) after all, the administrator will still notify the qualified beneficiary within 14 days but explain the decision (in the same manner as any other denial of benefits under the Plan).

Notice addressed to the employee and husband or wife and sent to the home of the employee will be considered notice to both, as long as the husband or wife resides at that address (according to the most recent information available to the Plan). Notice addressed to either the employee or the husband or wife will also be considered notice to all other qualified beneficiaries residing at the same address (according to the most recent information available to the Plan).

Election of COBRA. Timing. After receiving notice from the Plan Administrator, each qualified beneficiary will have 60 days to elect continued coverage under COBRA. (If the notice arrives before the date on which coverage would otherwise have ceased, the qualified beneficiary will have 60 days from the date on which coverage would otherwise have ceased.)

Persons covered by an election. Election of continuation coverage is an individual election of each qualified beneficiary in accordance with the following rules:

- If an employee elect's continuation coverage for the employee, spouse/domestic partner and dependent children, the election is effective for the employee, spouse/domestic partner and dependent children; the spouse/domestic partner and dependent children do not have a separate election.

- If an employee fails to elect continuation coverage for the spouse/domestic partner and/or dependent children (regardless of whether the employee elects continuation coverage for the employee), the spouse/domestic partner and/or dependent children are entitled to elect continuation coverage independently of the employee.
- If a spouse/domestic partner elects continuation coverage for the spouse/domestic partner and/or dependent children, the election is effective for the spouse/domestic partner and/or dependent children; the dependent children do not have a separate election.
- If neither the employee nor the spouse/domestic partner elects continuation coverage for a dependent child, the dependent child is entitled to elect continuation coverage independently.

Method. Election of COBRA continuation coverage will be made by returning to the Plan Administrator, properly completed and signed, such form as the Plan administrator may require (and supply with the notice of the qualifying event). The form may be returned at any time during the 60-day period described above.

Even if a qualified beneficiary returns the form during the 60-day period showing an election *not* to take COBRA continuation coverage, the qualified beneficiary may change his or her mind and elect continuation coverage by completing, signing and returning another form within the 60-day period described above.

Though the form supplied by the Plan Administrator is the preferred and usual method for making the election, any other method will be accepted that contains all of the information necessary to process the election.

Please note: Failure to elect COBRA continuation coverage within the 60-day deadline described in this section will constitute a complete, final and permanent waiver of COBRA continuation coverage.

Effect. The coverage offered for election will be the same coverage that the qualified beneficiary had immediately before the qualifying event—no more, no less, no changes.

Upon valid election, coverage will be provided retroactively to the date of the qualifying event, except that, if the qualified beneficiary first completes and returns a form showing an election *not* to take COBRA continuation coverage but later (within the 60-day period) completes and returns another form electing to *take* COBRA continuation coverage, the continuation coverage will be provided prospectively only—from the date when the second form was returned—and not retroactively to the qualifying event.

Regardless of the date as of which COBRA continuation coverage is provided, no claims will be paid for expenses incurred after the qualifying event unless and until the COBRA premium is timely paid (as described below).

Disclosure to health care providers. If an individual is a qualified beneficiary but has not made an election and the election period has not yet expired, health care providers who inquire as to the coverage status of the individual will be told exactly that—that the individual is not presently covered but has a right to elect coverage that will be retroactive to the qualifying event as long as the COBRA premium is timely paid. Likewise, if an individual who is a qualified beneficiary has timely elected continuation coverage but has not yet paid the first COBRA premium, health care providers who inquire as to the coverage status of the individual will be told exactly that—that the individual is not presently covered but has elected

continuation coverage, which will be retroactive to the qualifying event if and when the first COBRA premium is timely paid.

Children born during COBRA coverage. Children born to (or placed for adoption with) an employee who is receiving continuation coverage are considered to be qualified beneficiaries and therefore are eligible to receive continuation coverage on the same basis as any other child of the employee. This really means born to or placed for adoption with the employee, not born to or placed for adoption with a dependent child, for example.

If the employee's original COBRA election included children born (or placed for adoption) during the employee's continuation coverage, no further COBRA election is needed, but no coverage will be provided until the employee notifies the Plan Administrator that the child has been born (or placed for adoption).

If the employee's original election of continuation coverage did *not* include children born (or placed for adoption) during the employee's continuation coverage, an employee who wants coverage for the newly born (or placed) child should notify the Plan Administrator as soon as possible and complete a COBRA election form.

There is no deadline for this notice, but the employee should notify the Plan Administrator as soon as possible. Coverage will be provided retroactively to the date of birth (or placement for adoption) if possible under the rules of the Plan. If the notice is not given promptly, the Plan may not be able to provide continuation coverage retroactively to the date of birth (or placement for adoption).

Paying for COBRA coverage. COBRA continuation coverage will be provided to the qualified beneficiary only if the qualified beneficiary pays the applicable premium for such coverage plus a 2% administrative charge, with two exceptions:

- Qualified beneficiaries who are receiving an additional 11 months of continuation coverage due to disability will pay during those additional 11 months an amount equal to 150% of the applicable premium (as long as the individual who was disabled is receiving continuation coverage). Note that if a second qualifying event occurs during the first 18 months after the original qualifying event, as a result of which the duration of the continuation coverage is extended to 36 months, none of the additional 18 months are due to disability and this exception does not apply. Conversely, if a second qualifying event occurs more than 18 months after the original qualifying event, as a result of which the duration of continuation coverage is extended to 36 months, the 150% payment will remain in force beyond 29 months for the balance of the 36 months (as long as the individual who was disabled is receiving continuation coverage).
- Where the qualifying event is the employee's absence due to service in the uniformed services of the United States (meeting the requirements of the federal Uniformed Services Employment and Reemployment Act of 1994) and the employee performs such service for less than 31 days, the charge for COBRA coverage is limited to the employee contribution required of active employees.

The applicable premium will equal the actual cost to the group health Plan of providing the same coverage to participants and beneficiaries of the group health Plan who have not suffered a qualifying event. (If the coverage is not insured, the applicable premium will be determined on an actuarial basis as provided in COBRA.) For example, if a spouse/domestic partner or dependent child elects COBRA continuation

coverage and there is no employee coverage, so that the spouse/domestic partner or dependent child must be enrolled as if he or she were an employee, the applicable premium will be the premium for employee-only coverage.

Payment for all months up to and including the month in which the qualified beneficiary returns the election form to the Plan Administrator must be made to the Plan Administrator within 45 days after the election form is returned to the Plan Administrator. Payment for months following the month in which the election form is returned to the Plan Administrator must be made by the first of the month for which payment is made. Payment should be made payable to Deputy Executive Director at 76 Stephanie Drive, Salinas, CA 93901.

Please note: It is the responsibility of the qualified beneficiary to make timely premium payments. The Plan Administrator does not send bills or reminder notices.

Coverage received on COBRA. A qualified beneficiary who timely elects and pays for COBRA continuation coverage will receive the same coverage as similarly situated participants in the group health Plan who have *not* suffered a qualifying event. For example, and not by way of limitation, changes in coverage, deductibles, co-pays and insurance carriers and providers applicable to participants who have not incurred a qualifying event will apply equally to each qualified beneficiary.

Each such qualified beneficiary also has the same rights as a similarly situated participant who has not suffered a qualifying event to participate in open enrollment period and make changes in his or her coverage, including, for example and not by way of limitation, the right to add a spouse/domestic partner or dependents. (Except for a child born to or placed for adoption with an employee who is receiving continuation coverage, a spouse/domestic partner or dependent child added in this manner is not and can never become a qualified beneficiary.)

Duration of COBRA coverage. *Termination of employment or reduction in hours.* Where the qualifying event is termination of employment or reduction in hours, the maximum period of continuation coverage is 18 months from the date of the qualifying event.

As an exception, if an individual suffers a qualifying event by reason of absence due to service in the uniformed services of the United States as described in the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended by the Veterans Benefit Improvement Act of 2004, the maximum period of continuation coverage is 24 months from the date of the qualifying event.

As another exception, if a spouse/domestic partner or dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the "original qualifying event") but the employee had become covered by Medicare less than 18 months before the original qualifying event, then the maximum period of continuation coverage for the spouse/domestic partner and dependent child is 36 months from when the employee became covered by Medicare.

As another exception, if an employee, spouse/domestic partner or dependent child who is a qualified beneficiary by reason of the employee's termination of employment or reduction in hours (either because the individual chose continuation coverage or because the 60-day election period has not expired) is determined to have been disabled under Title II or XVI of the Social Security Act at any time during the 60 days after the original qualifying event (and fulfills the notice requirements previously described), then the maximum period of coverage for all such qualified beneficiaries is extended to 29 months from the date of the original qualifying event, regardless of whether the individual who is disabled chooses to have COBRA coverage. (In the case of a child born to, or placed for adoption with, an employee who is receiving

continuation coverage, the 60-day period begins when the child's COBRA coverage begins, which will usually be the date of birth or placement for adoption.)

Other qualifying events. Where the qualifying event is death, divorce or legal separation, Medicare coverage or cessation of dependent status, the maximum period of continuation coverage is 36 months from the date of the qualifying event.

Combinations of qualifying events. If a spouse/domestic partner or dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the "original qualifying event") and the employee thereafter dies or becomes entitled to Medicare or the employee and spouse/domestic partner are divorced or legally separated (and the subsequent event would have been a qualifying event if the employee had not suffered the original qualifying event), then the maximum period of continuation coverage for the spouse/domestic partner and dependent child is extended to 36 months from the date of the original qualifying event.

If a dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the "original qualifying event") but ceases to be a dependent child, then the maximum period of continuation coverage for the dependent child is extended to 36 months from the date of the original qualifying event.

Termination before maximum period has expired. Continuation coverage for a qualified beneficiary will be terminated automatically if and when:

- the qualified beneficiary first becomes covered under any other group health Plan after the date of election (effective June 8, 1998, continuation of other coverage that the qualified beneficiary may have had before the qualifying event, such as coverage as a dependent under the spouse/domestic partner's group health Plan, will not trigger termination under this paragraph), unless the other group health Plan excludes or limits coverage for a pre-existing condition that the qualified beneficiary has and that exclusion or limitation is neither barred nor satisfied by the qualified beneficiary under the federal Health Insurance Portability and Accountability Act of 1996, or
- the qualified beneficiary first becomes covered by Medicare after the date of the election (effective June 8, 1998, continuation of Medicare coverage that the qualified beneficiary may have had before the qualifying event will not trigger termination under this paragraph), or
- the qualified beneficiary is receiving extended coverage by reason of disability and ceases to be disabled, or
- payment of the required COBRA premium is not timely made (including any grace period afforded to the employer by an insurance company, but at least 30 days, and including the right of the qualified beneficiary to make up any deficiency in a partial payment within 30 days after notification from the Plan Administrator that the payment was not for the full amount due), or
- the employer ceases to provide any group health Plan to any employee.

If the group health Plan under which a qualified beneficiary is receiving COBRA continuation coverage terminates but the employer continues to provide one or more group health Plans, the qualified beneficiary will be afforded the same opportunity as participants with respect to whom a qualifying event has not occurred to participate in an alternate group health Plan of the employer.

Conversion privilege. COBRA continuation coverage will not affect any right of any individual to conversion coverage under any insurance contract. For example, if an individual elects COBRA continuation coverage under a group health Plan whose benefits are provided through an insurance contract that includes a conversion privilege at the conclusion of group coverage, the conversion privilege will be available when group coverage ends, *i.e.*, at the conclusion of the COBRA continuation coverage. Likewise, an individual who elects not to take COBRA continuation coverage may be entitled to a conversion policy at the time of the qualifying event.

Notice of premature termination of COBRA coverage from Plan administrator to qualified beneficiary. If a qualified beneficiary chooses to have COBRA coverage but the COBRA coverage ends before the maximum duration (18 months, 29 months or 36 months, as just explained), the Plan Administrator will notify the qualified beneficiary, provide the reason, and make note of the date of termination of COBRA coverage, as well as remind the individual about coverage alternates such as an individual policy (if available). This will apply, for example, where COBRA coverage is shut off because the qualified beneficiary is not making the required payments. The Plan Administrator will provide this notice as soon as practical after the decision is made. The same rules about the Plan Administrator's notice to employees, husbands and wives, and other qualified beneficiaries of a qualifying event (described above with regard to the original COBRA election) likewise apply to the Plan Administrator's notice of premature termination of COBRA in this section.

Miscellaneous provisions. Outside considerations. In considering whether to take COBRA, each qualified beneficiary should also consider how COBRA coverage relates to other rules. For example, when group health coverage terminates, federal law may guarantee you the right to buy an individual insurance policy from an insurance company in your state without being subject to a pre-existing condition limitation. But you may lose that right if you do not take COBRA and maintain it for the full duration. For another example, if you enroll in another group health Plan, the new group health Plan may be prohibited from imposing a pre-existing condition limitation, but only if you enroll in the new group health Plan within 63 days after your participation in this Plan terminates. Taking COBRA extends your participation in this Plan and thus may help you to avoid a gap of more than 63 days. And, finally, you may have a right to enroll in another group health Plan, such as the Plan of your husband or wife, if you do so within 30 days after your participation in this Plan terminates. Once again, taking COBRA coverage extends your participation in this Plan and may help you to avoid a gap of more than 30 days.

Health coverage tax credit. The federal Trade Act of 2002 created a health coverage tax credit, which can be used to help offset the cost of COBRA premiums, for certain individuals who become entitled to "trade adjustment assistance" or who have retired and are receiving pension payments from the federal Pension Benefit Guaranty Corporation. You can get information about the health coverage tax credit by calling the government's Health Coverage Tax Credit Customer Contact Center, toll-free at (866) 628-4282 or visiting www.irs.gov and searching for "HCTC."

Electronic notices. The general COBRA notification given when the employee and spouse/domestic partner join the Plan and the COBRA election provided when a qualifying event occurs may be given electronically, rather than by mail, if all of the following conditions are satisfied.

If the notice is to the employee, it is true that access to the employer's electronic information system is an integral part of the employee's duties and the employee has the ability effectively to access electronic documents at any location where the employee is reasonably expected to perform duties.

If the notice is to any qualified beneficiary (including the employee), it is true that:

- the person has affirmatively consented to receiving documents through electronic media (the consent may be in any form) and has not withdrawn consent;
- the person has given or confirmed consent electronically in a way that demonstrates their ability to access information electronically and provided an electronic address;
- before consenting, the person was provided with a notice explaining the types of documents to which the consent will apply, that the consent may be withdrawn at any time without charge, the procedures for withdrawing consent and updating the person's electronic address, the right to get a paper copy of any document that is furnished electronically (and the amount of any charge), and any hardware and software requirements for accessing and saving electronic documents;
- after the person gives consent, if a change in hardware or software requirements creates a material risk that the person will be unable to access or save the documents, the person is provided with a statement of the new hardware and software requirements, is given the opportunity to withdraw consent, and again consents as described above.

The Plan Administrator has taken appropriate and necessary measures reasonably calculated to ensure that:

- the system for furnishing documents electronically results in actual receipt of the documents (such as by using return-receipt or notice of undelivered electronic mail features or conducting periodic reviews or surveys to confirm receipt of the documents); and
- the system protects the confidentiality of personal information relating to the individual's accounts and benefits (such as by incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);
- the electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document;
- notice is provided to each intended recipient, in electronic or non-electronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted and of the right to request and obtain a paper version of the document; and
- upon request, the person is furnished with a paper version of the documents.

Change of address. It is important that all individuals who are, or may become, qualified beneficiaries keep the Plan Administrator up to date with their correct mailing address.

Questions. If you have questions about continuation coverage under COBRA, you should get in touch with the Deputy Executive Director at 76 Stephanie Drive, Salinas, CA 93901, telephone 831-755-0161.

Correction of mistakes. If at any time it is determined that a mistake has been made with regard to administration of COBRA continuation coverage, regardless of whether the mistake is favorable or detrimental to the employee, spouse/domestic partner or dependent, all feasible steps will be taken as soon as reasonably possible to correct the mistake by returning all affected parties to the position that they would have been in if the mistake had not occurred, including, if necessary, retroactive collection or refund of COBRA premiums and retroactive provision or denial of coverage.

APPENDIX C – PRIVACY PRACTICES HIPAA

Introduction. The Health Insurance Portability and Accountability Act of 1996 called for the U.S. government to regulate the use and disclosure of individually identifiable health information. It has done so through regulations issued by the Department of Health and Human Services. This section constitutes the Plan's HIPAA notice of privacy practices referred to in the regulations at 45 C.F.R. 164.520. As such, we are required to say here:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information. This section applies to "protected health information," which is health information that:

- is created or received by a health care provider, health Plan, employer or health care clearinghouse, and
- relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and
- identifies the individual (or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual).

Please note that employment records maintained by the employer in its capacity as employer are not "health information" and therefore cannot be "protected health information." This includes, for example, records of date of hire, employment classification and hours worked (even though that information may bear on eligibility for the Plan), as well as medical information developed to administer employment policies relating to paid time off, disability and workers' compensation, for example.

In this description, we will call protected health information "PHI" for short.

Treatment, payment and health care operations. The privacy rules generally allow the use and disclosure of your PHI without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations.

- Treatment includes providing, coordinating, or managing health care by health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share PHI about you with physicians who are treating you.
- Payment includes activities by the Plan, other Plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health Plan in order to coordinate payment of benefits.

- Health care operations include activities by the Plan (and in limited circumstances other Plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business Planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

Treatment, payment and health care operations may also include contacting you to provide appointment reminders or information about alternate treatments or about other health-related benefits and services that may be of interest to you.

The amount of PHI used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternates or other health-related benefits and services that may be of interest to you.

Other disclosures. In certain cases, your PHI can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your PHI may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your PHI without your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including:

- disclosures to workers' compensation or similar legal programs, as authorized by and necessary to comply with such laws,
- disclosures related to situations involving threats to personal or public health or safety,
- disclosures related to situations involving judicial proceedings or law enforcement activity,
- disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties,
- disclosures related to organ, eye or tissue donation, and transplantation after death,
- disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances by researchers regarding necessity of using your PHI and treatment of the information during a research project, and
- disclosures related to health oversight activities, specialized government or military functions and Health and Human Services investigations.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Request for restrictions. You may ask the Plan to restrict the use and disclosure of your PHI to treatment, payment, and health care operations, except for uses or disclosures required by law. You may ask the Plan to restrict the use and disclosure of your PHI to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of PHI to notify those persons of your location, general condition, or death or to coordinate those efforts with entities assisting in disaster relief efforts.

Your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Confidential communication of PHI. If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of PHI from the Plan by alternate means or at alternate locations.

Your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you. This right may be conditioned on your providing an alternate address or other method of contact and, when appropriate, on your providing information on how payment, if any, will be handled.

Inspecting and copying PHI. With certain exceptions, you may inspect or obtain a copy of your PHI in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a Plan; or a group of records the Plan uses to make decisions about individuals. As an exception, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

Your request to the Plan must be in writing. If your request is denied, you may request a review of the denial. If the Plan doesn't maintain the PHI but knows where it is maintained, you will be informed of where to direct your request.

Amending inaccurate or incomplete PHI. With certain exceptions, you may request that the Plan amend your PHI in a designated record set. Your request may be denied if the PHI is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings). Your request to the Plan must be in writing, and you must include a statement to support the requested amendment.

Accounting of disclosures. You have the right to a list of certain disclosures the Plan has made of your PHI. This is often referred to as an "accounting of disclosures." Generally, you can get an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed above, unless otherwise indicated below. You may be entitled to an accounting of disclosures that the Plan should not have made without authorization from you. You may receive information on disclosures of your PHI going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective).

You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations,
- to you about your own PHI,
- incidental to other permitted or required disclosures,
- where authorization was provided, to family members or friends involved in your care (where disclosure is permitted without authorization),
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances, or
- as part of a “limited data set” (PHI that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

Your request to the Plan must be in writing. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Paper copy of this notice. If you are not receiving this notice on paper, you may have a paper copy from the Plan on request. Just contact the Plan Administrator.

Breaches. In the event of a “breach” of “unsecured” PHI, as defined in 45 C.F.R. § 164.402, if your PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed, you will be notified as provided in the regulation.

Effective date and changes. This privacy policy originally took effect with the applicable regulations (generally, April 14, 2003) or, if later, when the Plan was established. Changes may be made in accordance with the normal procedure for amending the Plan (described elsewhere), in which event you will receive a copy of the new policy as soon as possible.

Complaints. Complaints relating to your PHI should be directed to the Plan Administrator. You may also complain to the Secretary of the federal Department of Health and Human Services, 200 Independence Ave., Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

APPENDIX D – SHARING PHI WITH THE EMPLOYER

Introduction. Besides the general policy on privacy practices (in the previous section of this document), the regulations under the Health Insurance Portability and Accountability Act of 1996 call for Plan provisions detailing how PHI may be shared with the employer or employers who maintain this Plan. This section functions as the HIPAA Plan amendment referred to in the regulations at 45 C.F.R. §164.504(f). Words used in this section have the same meaning as in the previous section of this booklet, particularly “protected health information” or PHI.

Employment records. Employment records maintained by an employer in its capacity as employer are not “health information” and therefore cannot be “protected health information.” This includes, for example, records of date of hire, employment classification and hours worked (even though that information may bear on eligibility for the Plan), as well as medical information developed to administer employment policies relating to paid time off, disability and workers’ compensation, for example.

Disclosure to and use by the employer. PHI may be disclosed to, and used by, the employer for the purpose of carrying out Plan administration functions that the employer performs, as long as the disclosure and use comply with the rest of this section. For example, this may include:

- determining eligibility for the Plan or actual coverage under the Plan,
- determining benefits under the Plan, including coordination of benefits and subrogation,
- determination of premiums,
- billing, claims management, collection activities, collecting on stop-loss insurance, and related data processing,
- determinations of medical necessity, appropriateness or justification of charges,
- utilization review, pre-certification, and concurrent and retrospective review,
- case management,
- credentialing doctors and hospitals, as well as training, accreditation, certification, and licensing,
- underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract or stop-loss contract (provided some additional rules are met),
- conducting or arranging for medical review, legal services and auditing functions,
- business Planning and development, such as conducting cost management and other analyses relating to managing and operating the entity, including development of formularies, methods of payment and coverage policies, and
- management and general administration of the Plan, including customer service, resolution of
- grievances, and due diligence in connection with a sale or transfer of assets to another Plan.

In addition, the employer may avail itself of any other exemption provided in the regulation.

PHI may not be disclosed to, or used by, the employer for any purpose other than carrying out the Plan administration functions that the employer performs. Specifically, PHI may not be disclosed to, or used by, the employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the employer.

Summary health information. The Plan (or any insurance company, including HMO's) may also disclose PHI to the employer if the employer requests it for the purposes of (a) obtaining premium bids from health Plans for providing health insurance coverage under the Plan or (b) modifying, amending or terminating the Plan, as long as the information is in summary form. Summary form means that the information summarizes claims history, claims expenses or types of claims under the Plan and is "disidentified" in accordance with the regulation, except that it need only be aggregated to the level of five-digit zip codes.

Other protections for PHI. Except as just described with respect to summary health information, the employer agrees:

- not to use or further disclose PHI except as permitted or required by the Plan (including this section) or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the employer, including implementation of reasonable and appropriate security measures;
- not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the employer;
- to report to the Plan any use or disclosure of the PHI which it receives under this section that is inconsistent with these rules of which it becomes aware;
- to provide access to PHI about an individual to that individual in accordance with the regulations (45 C.F.R. § 164.524);
- to make PHI available for amendment and incorporate any amendments in accordance with the regulations (45 C.F.R. § 164.526);
- to make available the information required to provide an accounting of disclosures in accordance with the regulation (45 C.F.R. § 164.528);
- to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining compliance with the regulation by the Plan;
- to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- to ensure that the adequate separation required by the regulation (45 C.F.R.)
- 164.504(f)(2)(iii) is established and supported by reasonable and appropriate security measures; and
- if feasible, to return or destroy all PHI received from the Plan that the employer still maintains in any form, and retain no copies, when no longer needed for the purpose for

which the disclosure was made and, if not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Disclosure to and use by others. PHI may be disclosed to and used by entities other than the employer only pursuant to a “business associate” agreement assuring that the PHI will be used only for treatment, payment or health care operations.

Sheltering PHI in the hand of the Employer. The following are all of the employees (or classes of employees) who may be given access to PHI in the hands of the employer:

- ▶ Executive Director
- ▶ Deputy Executive Director
- ▶ Eligibility Coordinator
- ▶ Catalize Health

Those individuals may use and disclose PHI only for the purpose of the plan administration functions that the employer performs for the plan.

If you believe that any of those employees are not complying with their obligations with regard to privacy of PHI, please notify the Plan Administrator, who will investigate and recommend appropriate disciplinary action if violations are found.

ACCEPTANCE OF RESPONSIBILITY BY EMPLOYER

Please sign below to acknowledge your acceptance of responsibility for the contents of this document and return this signed form to:

Catilize Health
2605 Nicholson Road
Suite 1140
Sewickley, PA 15143
or
Fax to: 724-934-3328

We, the employer referenced in this Plan document, recognize that we have full responsibility for the contents of the Plan Document and that, while Catilize Health, its employees, and / or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee benefit Plan.

Approval and acceptance of the Plan Document is hereby made on behalf of MCSIG:

Neddie Sarmiento

Neddie Sarmiento
Executive Director

Date: 3/7/2024