COMPASS FAMILY SERVICES
SELF-FUNDED HEALTH REIMBURSEMENT PLAN

Summary Plan Description

Originally Effective January 1, 2012
Amended and Restated as of January 1, 2022

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PLAN INFORMATION

This document, when incorporated with the plan document, summary plan description, benefit booklets and certificates, and provider contracts, policies, and descriptions related to this Plan and the Kaiser Group Health Plan (each referred to herein as the "Applicable Health Plan"), collectively the "Benefit Documents," constitutes this Plan's Summary Plan Description ("SPD") pursuant to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This is not the official Plan Document.

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan's benefits as of January 1, 2022 which may change from time to time. You should keep this SPD with the Benefit Documents provided to you upon enrollment in the Plan.

Plan Name:	Compass Family Services Self-Funded Health Reimbursement Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	The Plan Year of the Plan is January 1 through December 31 of the same calendar year
Plan Number:	503CFS0112
Effective Date of this SPD:	January 1, 2022
Original Effective Date of Plan:	January 1, 2012
Funding Method:	Self-Insured
Source of Contributions:	From general assets of Compass Family Services
Plan Sponsor and Plan Administrator:	Compass Family Services 37 Grove Street San Francisco, CA 94102 415-644-0504
Plan Sponsor's Employer Identification Number:	94-1156622
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrator:	Marin Benefits Administrators 6366 Commerce Blvd., Suite 293 Rohnert Park, CA 94928 415-526-1401 marinbenefits.com

For additional information regarding the Plan, contact Compass Family Services at 415-644-0504 or refer to the applicable Benefit Documents. Copies of the Benefit Documents are available free of charge from Compass Family Services or from Marin Benefits Administrators.

INTRODUCTION

Establishment, Purpose, and Definitions

Plan Sponsor maintains the Plan for the exclusive benefit of, and to provide welfare benefits to, its eligible employees and their eligible Spouses and Dependents. The Plan is a Health Reimbursement Arrangement Plan that is integrated with the Applicable Health Plan. It is intended that the Plan meet the requirements for qualification under Code §105.

The Plan is provided at no cost to you. The purpose of the Plan is to reimburse you, up to certain limits, for your own and your Spouse's and Dependent(s)' Medical Care Expenses on a nontaxable basis from a health reimbursement account. Reimbursements for Medical Care Expenses paid by the Plan generally are excludable from your taxable income. Note, however, that you may be required to contribute toward your and your Spouse's and Dependent(s)' coverage under the Applicable Health Plan.

It is intended that the terms of this Plan are legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees and their covered Dependents.

This SPD describes the basic features of the Plan and how it operates. It is only a summary of the key parts of the official Plan Document and a brief description of your rights as a Participant in the Plan. This SPD is not intended to give any substantive rights to benefits that are not already provided for in the official Plan Document and the Benefit Documents. Accordingly, if the terms of this SPD conflict with the terms of the official Plan Document, the terms of the official Plan Document will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this SPD with respect to the legal compliance requirements of ERISA and any other federal law, this SPD will control, unless superseded by applicable law.

For purposes of this SPD, the following definitions apply:

Benefits means the reimbursement benefits for Medical Care Expenses as described in this SPD.

Claims Administrator means Marin Benefits Administrators.

Code means the Internal Revenue Code of 1985, as amended.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent has the meaning set forth in Appendix A.

Employee means an employee as defined under the Applicable Health Plan.

Employer means Compass Family Services.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HRA or HRA Account means a health reimbursement arrangement account as described in this SPD.

Medical Care Expenses has the meaning defined in Appendix B.

Participant means an individual who is an Eligible Employee and who is participating in this Plan in accordance with the eligibility and participation rules listed in this Plan and in Appendix A.

Plan means the Compass Family Services Self-Funded Health Reimbursement Plan.

Plan Administrator means Compass Family Services.

Plan Sponsor means Compass Family Services.

Plan Year means January 1 through December 31 of the same calendar year.

QMCSO means a qualified medical child support order, as defined in ERISA §609(a).

Spouse has the meaning defined in Appendix A.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Eligibility Rules

Please refer to Appendix A of this SPD to determine your eligibility for participating in the Plan.

HRA Participation

If you become a Participant, the Plan will maintain an HRA in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Plan Sponsor), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from the Applicable Health Plan and any secondary health insurance coverage or health flexible spending accounts (if applicable) before any benefits are payable from this Plan.

If your participation in the Plan has ceased due to cessation of employment with Employer and you later return to employment you must meet the Plan's then current re-entry guidelines for participation in the Plan.

Enrollment and Elections

Initial Enrollment. You will become a Participant in this Plan by properly and timely completing an enrollment form or enrolling online for coverage under the Applicable Health Plan. If you do not properly and timely enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

Annual Open Enrollment. You may change your Applicable Health Plan election (or enroll in the Applicable Health Plan if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year depending on the policies adopted by Plan Sponsor.

Special Enrollment. You may change your elections regarding the Applicable Health Plan if you have a special enrollment right and you timely notify Plan Administrator. Please refer to the Plan Document, Summary Plan Description, and Benefit Documents for the Applicable Health Plan to understand your special enrollment rights under the Applicable Health Plan.

Waiver of Participation. If you participate in the Plan, you will be ineligible to make Health Savings Account ("HSA") contributions. You can remove the Plan as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your participation in the Plan before the beginning of that Plan Year. Whether you elect to suspend your coverage is up to you.

You may elect to suspend your participation in the Plan for any future Plan Year by submitting a Waiver of Participation Form to the Plan Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your participation in the Plan for a Plan Year, you agree to permanently forgo reimbursements from the Plan for Medical Care Expenses incurred during that Plan Year, except for limited-scope dental or vision expenses that qualify as excepted benefits for HIPAA purposes. Medical Care Expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year.

If you suspend your participation in the Plan for a Plan Year, the Employer will suspend contributions to the HRA Account for that Plan Year.

In lieu of a suspension of your Plan participation, you may elect to permanently opt out of and waive any right to future reimbursements from the Plan for expenses incurred after the election takes effect, except for limited-scope dental or vision expenses. Medical Care Expenses incurred before the opt-out election takes effect may be reimbursed during the first Plan Year to which the opt-out election applies, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred. If you permanently opt-out of this Plan, the Employer will discontinue contributions to your HRA Account. The Plan Administrator will offer this opt-out opportunity to you on an annual basis.

Dependent Coverage under QMCSOs

The Plan may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child in the Plan. You

may obtain a copy of the Plan Administrator's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

A QMCSO, as defined in ERISA §609(a), is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a Participant or beneficiary is eligible under the Plan, and that Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Continuation of Coverage Rights

COBRA is a federal law that gives certain Employees, Spouses, and Dependents the right to temporary continuation of health care coverage. See the "Continuation of Coverage Rights" section of this SPD for additional details on a Participant's, Spouse's or Dependent's right to continue benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

HRA BENEFITS AND ESTABLISHMENT OF ACCOUNTS

Benefits

Please refer to Appendix B of this SPD for details regarding the Plan's Benefits, including the allowable benefit maximum available to you for the Plan Year. Participants receive Benefits in the form of reimbursements of Medicare Care Expenses. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Before the start of each Plan Year, the Plan Administrator will determine a maximum annual amount that may be credited during that Plan Year to your HRA. Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses incurred by you, your Spouse, or your Dependents. Note that your Spouse and Dependents also must be enrolled in the Applicable Health Plan in order to be eligible for Benefits under this Plan.

Establishment of HRA Accounts

Once you become a Participant, the Plan will maintain an HRA Account in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account – it is not funded (all reimbursements are paid from the general assets of Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from the Applicable Health Plan and any secondary health insurance coverage before any Benefits are payable from this Plan.

Depending on the funding method adopted by the Employer, the entire annual contribution to your HRA Account will be available to you on the first day of the Plan Year or in equal portions throughout the Plan Year, so long as you are covered under the Applicable Health Plan and an Employee eligible for the Plan at the time your account is funded. Please see Appendix B for more details on crediting of your HRA Account.

Debiting HRA Accounts

The Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA. See Appendix B for details on filing a claim for your Benefits.

The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA as of such date, reduced by prior reimbursements made to you as of that date.

Reimbursement After Termination

When a Participant ceases to be a Participant in the Plan, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates, except to the extent the Participant is entitled to continuation of coverage rights under COBRA or applicable law. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant files a claim within ninety (90) days following the close of the Plan Year in which the Medical Care Expense arose.

Recovery of Overpayment

You must immediately repay any excess or improper payments or reimbursements paid to you, your Spouse or your Dependents by the Plan in error. Excess or improper payments may be recouped in accordance with applicable Internal Revenue Service guidance.

Coverage During Leaves of Absence

You may be eligible to continue Benefits under the Plan for a period of time during a leave of absence, subject to the leave policies and procedures adopted by the Employer and to the extent prescribed by law. If the Employer is subject to the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee eligible to participate in the Plan. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation in the Plan. The Employer shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law. For more information on coverage during leaves of absence, please refer to the Benefit Documents for the Applicable Health Plan or contact the Employer.

CONTINUATION OF COVERAGE RIGHTS

This Plan is integrated with the Applicable Health Plan and, as a result, COBRA coverage is only available to the extent it is available under the Applicable Health Plan. Nevertheless, this SPD generally describes your rights to continue coverage under the Plan pursuant to federal COBRA. Please refer to the Benefit Documents for the Applicable Health Plan for additional continuation of coverage information.

Introduction

In the event the Employer employs 20 or more employees in the preceding year, the following federal COBRA provisions apply to certain health care benefits offered under this Plan. Nothing in this section is intended to expand your rights beyond COBRA's requirements or the requirements of any other applicable federal or state law.

COBRA Coverage is a continuation of the Plan's COBRA-eligible benefits when your coverage would otherwise end due to a life event known as a "qualifying event" (as described below). After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary," which may include you, your Spouse, and/or your Dependent children. If elected, you must pay the full cost of the COBRA Coverage (including both employer and employee contributions) as described in the "Cost of COBRA Continuation Coverage" section.

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact the Plan Administrator.

Other Coverage Options

Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA Coverage. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Qualifying Events for COBRA Coverage

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

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

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA Coverage.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- The employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Notifying the Plan of a Qualifying Event

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. However, when the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA Coverage to qualified beneficiaries without notification that such a qualifying event has occurred.

You Must Notify the Plan Administrator of Certain Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and Spouse or a Dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, Spouse or Dependent who underwent the qualifying event. You must provide this notice to:

Compass Family Services
Attention: Human Resources
37 Grove Street
San Francisco, CA 94102
415-644-0504

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

COBRA Coverage Elections

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries who then will have an independent right to elect coverage. Covered employees may elect COBRA Coverage on behalf of their spouses, and parents may elect COBRA Coverage on behalf of their children.

If mailed, your election must be postmarked (or if hand delivered, your election must be received by the individual at the address specified on the election form) no later than 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event (or, if later, 60 days after the date that Plan coverage is lost).

Length of COBRA Coverage

The COBRA Coverage periods described below are maximum coverage periods. COBRA Coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Early Termination of COBRA Coverage" section below.

Employee Coverage. Under COBRA, employees themselves are only eligible for either:

- 18 months of coverage, due to termination of employment or a reduction in hours; or,
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is determined to be disabled by the Social Security Administration before the 60th day of COBRA Coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

COBRA Coverage will be available to the employee and any covered family members. Additionally, under USERRA, covered employees who enlist in the military or are called to active duty may have COBRA-like coverage rights for themselves and their dependents that last for up to 24 months.

Dependent/Qualified Beneficiary Coverage. Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

- 36 months of coverage, due to losing dependent-child status under the plan;
- Up to 36 months of coverage, when the qualifying event is the employee's termination of employment or a reduction in hours and the employee became entitled to Medicare less than 18 months before the qualifying event (where the 36 months is measured from the date the employee became entitled to Medicare); or,
- Up to 36 months of coverage, when there is a second qualifying event during continuation coverage (the death of the covered employee; the divorce or separation of the employee and Spouse; the covered employee becoming entitled to Medicare or loss of dependent-child status under the Plan), where the 36 months is measured from the original COBRA Coverage start date.

  These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

Notification Requirement for Extensions. The extension of COBRA Coverage due to a disability or another second qualifying event is available only if you notify the Plan Administrator in writing within 60 days after the qualifying event. You must provide this notice to:

Compass Family Services
Attention: Human Resources
37 Grove Street
San Francisco, CA 94102
415-644-0504

For the disability extension, the notice must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, to be entitled to a disability extension, you must provide the notice within 18 months after the covered employee's termination of employment or reduction of hours.

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

Early Termination of COBRA Coverage

COBRA Coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that the you must notify the Plan Administrator in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. Note that you must notify the Plan Administrator in writing within 30 days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;
- The Employer ceases to provide any COBRA-eligible group health plan coverage for its employees; or,
- For any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving COBRA Coverage. The amount of your COBRA

premiums may change from time to time during your period of COBRA Coverage and will most likely increase over time. You will be notified any COBRA premium changes.

Payment for COBRA Coverage. If you elect continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for COBRA Coverage no later than 45 days after the date of your election (this is the date the envelope containing the payment is post-marked, if mailed). **If you do not make your first payment for COBRA Coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan**. You are responsible for making sure that the amount of your first payment is correct and paid in a timely manner.

After you make your first payment for COBRA Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA Coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates**.

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA Coverage will continue for each coverage period if payment for that period is made before the end of the grace period for that payment.

Plan Contact Information

In order to protect your and your Spouse's and Dependent's rights, you should keep the Employer and Plan Administrator informed of any changes in your address and the addresses of family members.

Compass Family Services
Self-Funded Health Reimbursement Plan
37 Grove Street
San Francisco, CA 94102
415-644-0504

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions may generally apply to the Applicable Health Plan associated with your HRA: Title VII of the Civil Rights Act of 1964, Newborns' and Mothers' Health Protection Act of 1996, Women's Health and Cancer Rights Act of 1998, Affordable Care Act, Mental Health Parity and Addiction Equity, the Genetic Nondiscrimination Act, and the Consolidated Appropriations Act of 2021. For more information regarding your rights under these laws, please refer to the Benefit Documents for the Applicable Health Plan.

Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures must be followed by Plan Participants to obtain payment of benefits under the Plan, but only to the extent not otherwise provided in the applicable Benefit Documents. If the claims and appeal procedures in this section apply, they shall be construed and applied in a manner consistent with the ACA and the Department of Labor ("DOL") Regulation Section 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

HRA Reimbursements

The Plan Administrator will act as, or will designate, a claims administrator to decide your claim ("Claimant") in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If the claims administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal for a review of the denied claim. The claims administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by and other applicable law.

Reimbursements under the Plan must be submitted pursuant to procedures established by the claims administrator (see Appendix B for additional details).

Debit Card Payments. Payments from your HRA for qualified Medical Care Expenses will occur automatically if you pay your health care provider using a debit card provided by the claims administrator. You must comply with the card substantiation procedures by providing any requested documentation that supports your reimbursement.

Manual Submissions. In general, a Plan Participant may apply for reimbursement by submitting a request to the claims administrator in such form as the claims administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Medical Care Expense was incurred (or 90 days after the date eligibility ceases). At minimum, the request for reimbursement must include:

- The name of the person or persons who incurred the Medical Care Expenses;
- The nature and date of the expenses so incurred;
- The amount of the requested reimbursement;
- A statement that such expenses have not otherwise been reimbursed and that the Claimant will not seek reimbursement through any other source; and,
- Other such details about the expenses that may be requested by the claims administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Claimant).

The reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such expenses, along with any additional documentation that the claims administrator may request.

Requests for reimbursement should be sent to:

Marin Benefits Administrators
6366 Commerce Blvd, Suite 293
Rohnert Park, CA 94928
Fax paid claim form to 415-454-2928
Online claim submission: www.marinbenefits.com

Claims Administrator's Procedures

Within 30 days after receipt by the claims administrator of a reimbursement request from Claimant, the claims administrator will reimburse the Claimant for the Medical Care Expenses (if the claims administrator approves the claim), or the claims administrator will notify the Claimant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the claims administrator, including in cases where a reimbursement claim is incomplete. The claims administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Claimant 45 days in which to complete the previously incomplete reimbursement claim.

If the claims administrator does not fully agree with the claim, the Claimant shall receive an adverse benefit

determination ("Adverse Determination"). The Notice of Adverse Determination must be written in a manner calculated to be understood by the Claimant and shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the applicable time limits;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- If applicable, specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. Such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) after an appeal.

HRA Claims Appeal Procedures

First Appeal. If the Claimant disagrees with an Adverse Determination, the Claimant or the Claimant's appointed representative may formally request an appeal by following the claims administrator's appeal procedures. The Claimant may appeal any Adverse Determination within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. If the Claimant does not appeal in a timely manner, the Claimant will lose the right to later object to the adverse determination on review ("Appeal Decision").

If the claim on appeal is wholly or partially denied, the claims administrator will provide the Claimant with a written notification of the Plan's Appeal Decision, within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan. Any determination by the claims administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the claims administrator or delegate acted arbitrarily and capriciously. The notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Plan provisions on which the Appeal Decision is based;
- A statement regarding the Claimant's right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about such procedures;
- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a).

Second Appeal. If specified in the Benefit Documents for the HRA or in documentation given to you by the Plan Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The Appeal Decision with respect to any second appeal will be made within a reasonable period of time, but not later than 30 days after receipt of the second appeal by the Plan.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust the Plan's claims and appeal procedures as a prerequisite to filing a lawsuit for benefits. However, this will not apply if the error was de minimis, if the error does not cause harm to you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. You may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative

remedies available under the Plan to be deemed exhausted.

Exhausting Administrative Remedies and Filing Suit

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. **If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD, you may lose the right to file suit in state or federal court.**

A lawsuit seeking benefits under this Plan must be brought within certain time limits as detailed in the "Legal Actions" section of this SPD and in accordance

PLAN ADMINISTRATION

In General

The Plan Administrator of the Plan is the "Named Fiduciary" within the meaning of such terms under ERISA, who shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator is the Plan's agent for service of legal process.

Plan Administrator has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan Participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of Plan Administrator, furnish to Plan Administrator such data and information as Plan Administrator shall require in the performance of its duties under the Plan.

Plan Administrator may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

Plan Administrator may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

Plan Administrator will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Privacy and Security of Information

This Plan is a health plan subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations affecting the maintenance, creation or use of Protected Health Information ("PHI") (as defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Plan Amendment and Termination

Plan Sponsor reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of any balance in the HRA Account under this Plan. Any amendment, termination or other action by Plan Administrator will be done in accordance with Plan Administrator's normal operating procedures.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay

court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

Legal Actions

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of California.

The time limit for bringing any lawsuit that arises under or relates to this Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a component plan, you must complete the applicable claims procedure set out in the Plan, as applicable (and comply with all applicable deadlines). If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.
- You must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Right of Reimbursement from Third Parties

By participating in the Plan, you and your covered Spouse or Dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. Accordingly, you and your covered Spouse or Dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered Spouse or Dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered Spouse or Dependent to any payment, amount, or recovery from a third party.

You and your covered Spouse or Dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable for you or your Spouse or Dependents under the Plan may not be assigned to anyone. Additionally, to the extent any assignment of benefits is permitted under the Plan, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. As such, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this SPD is a general discussion of the relevant provisions of the Plan found in the official Plan document and any component plan Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

COMPASS FAMILY SERVICES SELF-FUNDED HEALTH REIMBURSEMENT PLAN
SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Eligibility

A regular full-time or part-time employee of the Employer enrolled in the Applicable Health Plan. A full-time employee is considered to be an individual who is regularly scheduled to work 37.5 or more hours a week. A part-time employee who is regularly scheduled to work 22.5 or more hours a week is also eligible.

If, based on the facts and circumstances on the start date of a new Employee, the Plan Administrator determines that such Employee is not reasonably expected to be employed an average of at least 22.5 hours of service per week or is a seasonal employee, then the Plan Administrator shall determine the employee's eligibility or ineligibility for the Applicable Health Plan based on special eligibility rules for variable hour, seasonal, and part-time employees as documented and described under the Applicable Health Plan.

Waiting Period. You are eligible to participate in the Plan on the first day of the month following your date of hire.

Effective Date of Coverage. You will commence participation in the Plan on the first day of the month following your date of hire.

Dependent Eligibility

Unless specified otherwise under the Applicable Health Plan Benefit Documents, coverage for Spouses or Dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage).

Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions shall have the same meaning set forth in the Applicable Health Plan's Benefit Documents which are incorporated by reference herein. Unless otherwise defined in the applicable Benefit Documents, your eligible dependents include:

- Your Spouse, as defined in the Applicable Health Plan, which is the legal Spouse as defined under the Code or Domestic Partner of an Eligible Employee.
- Your child(ren) under age 26 (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred before age 26. For purposes of the Plan, a child includes:
  - Your (or your spouse's/domestic partner's) natural child, stepchild, legally adopted child (including any child lawfully placed for adoption with you); and,
  - A child for whom you have court-appointed legal guardianship that is chiefly dependent on you for support and maintenance.
- An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

Cessation of Participation

If you cease to be an eligible employee because you are no longer covered by the Applicable Health Plan, your participation will terminate when your Applicable Health Plan coverage ends.

If you cease to be an eligible employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described in this SPD. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the HRA, provided that you comply with the reimbursement request procedures required under the Plan. Any unused portions will be not be available after termination of employment. However, if you are rehired within 30 days after your termination, your HRA balance will be reinstated.

If your participation terminates, you will receive reimbursement for Medical Care Expenses incurred prior to your termination of participation if you apply for reimbursement within 90 days of the date the charges were incurred.

Changes in Family Status

If you change your Applicable Health Plan election from single to family coverage during the Plan Year, the increase in the annual contribution amount will be based on the date the family coverage begins. If you change your Applicable Health Plan election from family to single coverage during the Plan Year, the decrease in the annual contribution amount is applied at the time of the change. If an employee has already exhausted the single contribution amount at the time of the change, reimbursements from the HRA Account will not be permitted for the remainder of the Plan Year.

APPENDIX B

COMPASS FAMILY SERVICES SELF-FUNDED HEALTH REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

Schedule of Benefits

Effective for those meeting the eligibility and waiting period requirements identified in Appendix A.

Health Reimbursement Coverage

- **Benefits Provided.** The Plan provides reimbursement to participants for certain Medical Care Expenses that are incurred during the Plan Year and not otherwise reimbursed under the Applicable Health Plan or another health plan.
- **Medical Care Expenses.** Reimbursable Medical Care Expenses are those expenses that are deductible for tax purposes under IRC Section 213 or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses that are not excluded below.
- **Covered Expenses.** The Plan will reimburse up to 100% of the negotiated charges covered by the existing Kaiser high-deductible group medical plan. These expenses include eligible deductible charges, prescription drug payments, durable medical equipment and chiropractic expenses. Gold and platinum level participants may use HRA funds in excess of the deductible towards co-payments and co-insurance charges after the deductible has been satisfied.
- **Excluded Expenses.** The plan specifically excludes coverage for any services not covered by the existing Kaiser high-deductible group medical plan.
- **Maximum Annual Benefit for Existing Employees.** The maximum annual benefits under this plan are divided into four (4) tiers based upon your participation in Compass Family Services' wellness program prior to December 15, 2022. For wellness plan details go to compass.wellright.com. For existing employees, activities completed from January 1, 2021 through December 15, 2021 determined the funding for the 2022 plan year: January 1, 2022 through December 31, 2022. To have earned HRA funding in 2022, you must have participated in the program and have earned points in 2021. HRA funding tier levels are as follows:

Tier	Points Earned	Employee Only Funding	Family Funding
Bronze	0 - 249	$500	$1000
Silver	250 - 599	$1000	$2000
Gold	600 - 749	$2000	$3000
Platinum	750+	$2000	$3000

- **Newly Benefit Eligible Employees in 2022.** Any eligible employee (regular full-time or regular part-time) who is newly eligible for benefits between January 1st, 2022 and September 1st, 2022 will automatically be placed at the bronze level for 2022. The employee will be given the opportunity to receive gold level funding by logging on to compass.wellright.com and completing the following four (4) required company challenges:
  - Annual Physical Exam
  - Dental Exam
  - Health Quality Assessment
  - No Butts Tobacco-Free Affidavit or the SmokeFree Smoking Cessation Course

  Upon completion, the employee will be brought up to the gold level and will receive full funding for the remainder of the 2022 plan year AND the 2023 plan year.

  Any eligible employee (regular full-time or regular part-time) who is eligible for benefits between October 1st, 2022 and December 1st, 2022 will automatically be placed at the bronze level for 2022. The employee will be

given the opportunity to receive gold level funding by logging on to compass.wellright.com and completing the following two (2) required company challenges:

- Health Quality Assessment
- No Butts Tobacco-Free Affidavit or the SmokeFree Smoking Cessation Course

Upon completion, the employee will be brought up to the gold level and will receive full funding for the remainder of the 2022 plan year AND the 2023 plan year.

- **Nondiscrimination**. Benefits for Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator in its sole discretion.
- **Funding of HRA Account**. A Participant's HRA Account will be credited in full at the beginning of each Plan Year.
- **Forfeitures**. If any balance remains in the Participant's HRA Account for a Plan Year, such balance shall be forfeited. If a Participant ceases to be a Participant, expenses incurred after such time will not be reimbursed unless COBRA continuation coverage is elected.

Filing HRA Claims

1. You have received a debit card that has been preloaded with appropriate funds to pay for eligible Kaiser group medical plan expenses.
2. Submit your Health Reimbursement Claim, paid receipt or bill, along with a completed claim form to:

   Marin Benefits Administrators
   6366 Commerce Blvd., Suite 293
   Rohnert Park, CA 94928
   Fax paid claim form to 415-454-2928
   Online claim submission: www.marinbenefits.com

   The employee or eligible Spouse or Dependents may submit claims. Payment will be made to the Employee.
3. Claims must be filed within ninety (90) days of the end of the Plan Year or, in the case of dual coverage, date of payment from other plan, to be eligible for reimbursement.
4. Please refer to the Claims and Appeals Procedures in this SPD for further information.]

Health Reimbursement Benefits

After the Participant submits a valid receipt along with a completed claim form, as proof that a covered Participant, Spouse, or Dependent has incurred Medical Care Expenses eligible for reimbursement, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Claims must be submitted within ninety (90) days of the end of the Plan Year. The amount reimbursable from the HRA Account is subject to the Coordination of Benefits section of this SPD and the Plan as applicable.

Reimbursement of Expenses - Eligible Provider

In order to be reimbursed for expenses resulting from services of a health care provider, the services generally must have been provided by a properly licensed individual who is an eligible medical services provider or individual acting under his/her supervision as a technician, and the treatment received as part of the services must have been within the scope of his/her licensure and training.

Medical Care Expenses Exclusions

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to health reimbursement accounts:

- Expenses incurred prior to a Participant's effective date of coverage or after termination of coverage.

- Health insurance premiums for any other plan (including the Applicable Health Plan). Notwithstanding the foregoing, the HRA may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.
- Services which are considered by the Internal Revenue Service to be cosmetic and, therefore, taxable to the Participant.
- Long-term care services.
- Funeral and burial expenses.
- Custodial care.
- Bottled water.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code Section 213(d).

Questions

If you have a question about whether a particular expense is or is not reimbursable under the Plan, you should contact the Plan Administrator. The Plan Administrator has the discretionary authority to determine what expenses are reimbursable, taking into account the terms of this Plan, and rules contained in the applicable sections of the Code, and regulations and other IRS guidance thereunder.

Coordination of Benefits

The purpose of this Plan is to help you meet the cost of needed health care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. Benefits payable by this Plan and any other group medical plan may be coordinated so that the total benefits allowed will not exceed the amount which would have been allowed if no other plan were involved. All benefits provided hereunder are subject to this provision.

This Plan will always pay its regular benefit in full when it is the employee's primary plan. As a secondary Plan, this Plan may provide a reduced amount which, when added to the benefits payable by the other plan, will equal an amount not greater than 100 percent of the fee charged.

Right to Receive and Release Necessary Information

In order to determine this Plan's responsibility, the Employer or Administrator may, with or without notice to you, or without your consent, give to or get from any other plan, company or person any information need to coordinate benefits. When you file a claim with this Plan, you agree to provide, and give the Employer and Administrator your permission to give or get, any additional information needed to coordinate benefits.