

SUMMARY PLAN DESCRIPTION

FOR THE

**GREENBERG TRAURIG WELFARE BENEFIT PLAN AND CAFETERIA
PLAN**

August 2024

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION	1
II. PARTICIPATION	2
Employee Eligibility to Participate.....	2
Dependent Eligibility to Participate.....	2
Enrolling for Coverage	2
Special Enrollment.....	2
Mid-Year Changes	3
Termination of Coverage	5
III. COST OF COVERAGE	5
IV. BENEFITS	5
V. FLEXIBLE SPENDING ACCOUNTS	5
Health Care Flexible Spending Account.....	6
Dependent Care Flexible Spending Account.....	8
VI. HEALTH SAVINGS ACCOUNT	9
VII. SPECIAL PROVISIONS REGARDING HEALTH BENEFITS	10
Newborn’s and Mother’s Health Protection Act	10
Women’s Health and Cancer Rights Act.....	10
Mental Health Parity and Addiction Equity Act.....	10
Genetic Information Nondiscrimination Act.....	11
Medicaid and the Children’s Health Insurance Program (CHIP)	11
Affordable Care Act.....	11
Qualified Medical Child Support Orders (QMCSO).....	12
Continuation of Benefits During Leave.....	12
Continuation of Benefits for Military Leave	12
COBRA Continuation Coverage.....	12
Privacy of Health Information	16
VIII. AMENDMENT OR TERMINATION OF THE PLAN.....	17
IX. COST OF COVERAGE AND FUNDING.....	17
Cost of Coverage and Payment for Coverage.....	17
Source of Benefit Payments.....	18
Payment of Administrative Expenses	18
X. CLAIMS PROCEDURE.....	19
Filing Claims.....	19

Disability, Life and AD&D Claims	20
Health Care Claims	24
Discretionary Authority	31
No Transfer or Assignment of Benefits or Rights	31
Legal Action.....	31
XI. YOUR ERISA RIGHTS	31
Receive Information about Your Plan and Benefits	31
Continue Group Health Plan Coverage.....	32
Prudent Actions by Plan Fiduciaries.....	32
Enforce Your Rights	32
Assistance with Your Questions	32
XII. GENERAL PLAN INFORMATION	33
XIII. THIRD PARTY ADMINISTRATORS AND INSURANCE COMPANIES	35

SUMMARY PLAN DESCRIPTION FOR GREENBERG TRAUIG WELFARE BENEFIT PLAN AND CAFETERIA PLAN

I. INTRODUCTION

Greenberg Traurig, P.A. (“GT”) sponsors the Greenberg Traurig, P.A. Welfare Benefit Plan (“Welfare Plan”) and the Greenberg Traurig, P.A. Cafeteria Plan (“Cafeteria Plan”), which are maintained for the benefit of eligible employees and their eligible family members. The Welfare Plan provides medical, dental, vision, prescription drug, life, accidental death and dismemberment, disability, health flexible spending account (“Health FSA”) and employee assistance. The Cafeteria Plan permits eligible employees to pay their share of premiums towards benefits and make pre-tax contributions to a Health FSA, dependent care flexible spending account (“Dependent Care FSA”), and/or a health savings account (“HSA”). Please note that the Dependent Care FSA and the HSA are not subject to ERISA.

This summary, together with the summaries (including documents called summary plan descriptions, or SPD), booklets, certificates, evidence of coverage (“EOC”) or other materials describing the benefits, which are provided by the third party administrators (for the self-insured programs) or insurance companies or HMOs (the “Program Materials”) are your SPD. This SPD describes your benefits and rights as well as your obligations. It is important for you to understand that because this is only a summary, it cannot cover all the details of the Plans or how the rules will apply to every person in every situation. All the specific rules governing the Welfare Plan and the Cafeteria Plan are contained in the applicable official plan document. In the event there is any conflict between the SPD and the applicable plan document, the plan documents will always be followed in the actual determination of your benefits or rights. You can obtain copies of the Welfare Plan and/or Cafeteria Plan documents on GT’s intranet or by contacting HRBenadmin@gtlaw.com.

Certain benefits are provided through insurance and the insurance company will provide benefits and administer claims. Other benefits are self-insured and various vendors have been engaged to serve as the third party or contract administrators for the self-insured components of the Welfare Plan. The contact information for each third party or contract administrator is listed in the General Plan Information at the end of this SPD. These parties will be referred to as Contract Administrators. You should generally reach out to the parties listed for each component program. However, you can also contact the Plan Administrator listed in the General Plan Information at the end of this SPD.

II. PARTICIPATION

Employee Eligibility to Participate. You are generally eligible to participate in the Plans if you are a U.S. domestic regular employee who is regularly scheduled to work 30 or more hours per week (e.g. classified as “full-time”) and who satisfies the eligibility requirements for one or more of the Benefits Programs. You are not eligible if you are classified as an independent contractor or consultant, a leased, staffing or temporary agency employee, a part-time employee, or a project attorney employed fewer than 90 days. With respect to eligibility for medical care benefits, the Welfare Plan will comply with all requirements of the Patient Protection and Affordable Care Act of 2010, as amended.

Dependent Eligibility to Participate. In addition to yourself, you also may enroll your eligible dependents (also referred to in this SPD as “eligible family members”) for coverage in certain benefits. Eligible dependents may include your spouse, your domestic partner, your son, daughter, stepson, stepdaughter, adopted child (including a child placed for adoption), or children of your domestic partner through the end of the Plan Year in which they attain age 26, or a permanently and totally disabled child over age 26. Also see the Program Materials for a description of who qualifies as an eligible dependent.

Enrolling for Coverage. When you are first eligible to enroll for coverage, you will be provided enrollment information from the Plan Administrator and you must follow the enrollment procedures specified by the Plan Administrator in the enrollment information and open enrollment materials. You and your eligible family members will automatically receive coverage under certain benefit programs. Other benefit programs require that you elect to participate and elect your coverage level. Each fall, GT will hold an open enrollment period. During this time, you may elect coverage for the first time, may discontinue coverage, may enroll or discontinue coverage for your eligible family members, and may switch between the different component programs that are available to you.

Once you make an election to enroll in a benefit option for which you make pre-tax contributions through the Cafeteria Plan (e.g. medical, dental, vision, FSAs, dependent life), it is irrevocable for the rest of the Plan Year, except for your pre-tax contributions to your HSA. You cannot change your pre-tax elections for any benefit option under the Cafeteria Plan until a later open enrollment period or special enrollment period or until an event occurs that allows you to change your election (for example, you have a qualified change of status, your dependent changes their coverage under their employer’s plan, or a Qualified Medical Child Support Order (“QMCSO”) is issued).

Special Enrollment. If you initially declined to enroll in an underlying health plan because you had other coverage and later lose that other coverage, you may be able to enroll yourself or your dependents in the health care components of the Welfare Plan. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself or your dependents. A new election must be submitted within 30 days of these special enrollment events.

You and your dependents may also enroll in health benefits if you or your dependents have coverage through Medicaid or a state Children’s Health Insurance Program (CHIP) and you or

your dependents lose eligibility for that coverage or you become eligible for a premium assistance program through Medicaid or CHIP. If you believe you are eligible for such special enrollment you must request enrollment or de-enrollment within 60 days.

You may prospectively revoke coverage under an underlying group medical plan (but not the Health FSA) and make corresponding changes to your salary reduction contribution if you are eligible for a special enrollment period to enroll in a qualified health plan through a federal or state exchange or enrollment during the exchange's annual open enrollment period. For more information about special enrollment periods in the Exchanges, see <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

Mid-Year Changes. You may revoke your pre-tax election and make a new election under the Cafeteria Plan for the rest of the Plan Year if both the revocation and the new election are on account of and correspond with a "change in status" or other permitted mid-year election change described below (in addition to the special enrollment rights described above) that affects eligibility for coverage or another change as permitted by IRS rules.

A. **Change in Status.** The following events are **changes in status**:

- A change in legal marital status, including marriage, death of a spouse, divorce, legal separation (your legal separation or equivalent procedure must be legally recognized in your state of residence and you must have a court order), and annulment of a marriage.
- A change in number of dependents, including birth, death, adoption, and placement for adoption.
- A change in employment status that effects eligibility of the employee, spouse, or child, including commencement of employment, termination of employment, strike or lockout, commencement of an unpaid leave of absence, return from an unpaid leave of absence, or a change in worksite.
- Child satisfies or ceases to satisfy eligibility requirements as a dependent, including attainment of a particular age, loss of disability status, or similar circumstance.
- A change in place of residence of the employee, spouse, or child that affects eligibility for the availability of benefits.

B. **Judgment, Decree or Order.** If a judgment, decree or order from a court requires your dependent child to be covered under a health care component of the Welfare Plan, you may change your election to provide coverage for the child. Conversely, if the order requires another individual to provide coverage (and such coverage is provided) you may change your election to revoke coverage for your child. A new election must be submitted within 30 days. This does not apply to the Dependent Care FSA.

C. **Entitlement to, or Loss of, Medicare or Medicaid.** If you, your spouse and/or a dependent who is enrolled in health coverage becomes enrolled in Medicare or Medicaid, you may cancel or reduce coverage for the person who becomes enrolled in Medicare or Medicaid. Conversely, if you, your spouse and/or a dependent who was covered under Medicare or Medicaid loses this coverage, you are allowed to make an election to commence or increase coverage for the person who loses Medicare or Medicaid coverage. If there is a loss in

Medicaid coverage, the new election must be submitted within 60 days. This does not apply to the Dependent Care FSA.

- D. **Significant/Insignificant Changes in Cost.** If the cost of coverage under an underlying accident or health option significantly increases, you are allowed to increase contributions prospectively or elect similar coverage (if available) or revoke coverage if similar coverage is not available. If the cost of coverage under an underlying accident or health option significantly decreases, you are allowed to decrease your contributions prospectively or commence participation in the option with the decrease in cost. The basis of whether a change in cost is significant or insignificant is determined on a group level, not on an individual level. *Insignificant* cost increases or decreases (determined on a group level) will automatically apply. Regarding the Dependent Care FSA, you may choose to increase your contributions if the provider of services increases their fees during the Plan Year, as long as the provider of services is not a relative. Should you remove your dependent from child care or the need for child care decreases, you are allowed to decrease your Dependent Care FSA election accordingly. This does not apply to the Health FSA.
- E. **Significant Curtailment/Addition of Coverage, Significant Improvement or Drop of Benefit Package Option.** If coverage under an underlying accident or health option is significantly curtailed, you may revoke your election and elect another option with similar coverage. Also, if the Welfare Plan adds a new benefit or significantly improves a benefit during the Plan Year, you may elect the newly added option. If an existing accident or health option is dropped, you are allowed to choose another benefit option that provides similar coverage. This does not apply to the Health FSA.
- F. **Change in Coverage under another Plan.** You are allowed to make an election change that is on account of or corresponds with a change made under the plan of your spouse, former spouse, or dependent's employer, provided the employer permits participants to make an election change that would be permitted under the status change rules contained in this SPD, or the Cafeteria Plan permits you to make an election for a period of coverage that is different from the period of coverage under the plan of your spouse, former spouse, or dependent. This does not apply to the Health FSA or the Dependent Care FSA.
- G. **Loss of Coverage under Other Group Health Coverage.** You may add coverage for you, your spouse, or your dependent if coverage is lost under any group health plan sponsored by a governmental or educational institution. This does not apply to the Health FSA or the Dependent Care FSA.
- H. **FMLA.** You may revoke an existing health plan (including Health FSA) election and make a new election if you take an FMLA leave. This does not apply to the Dependent Care FSA.
- I. **Change in Contributions to HSA.** You may change or revoke your contributions to your HSA prospectively at any time. The change will be effective only after a valid election change has been received and processed by the Administrator.

Unless otherwise noted above, you must request the enrollment change within 30 days of the change in status by logging in to GT Workday and entering information about the event permitting the change. The change is effective as soon as administratively feasible after receiving and

approving the request (except for newborn or adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Termination of Coverage. Your coverage generally ends when you cease to be an eligible employee or terminate employment (subject to COBRA for health benefits), fail to pay your share of contributions (except during certain leaves of absence), if/when a benefit component is terminated, or at the times specified in the Program Materials. Dependent coverage may end earlier due to a loss of dependent status.

III. COST OF COVERAGE

You and GT may share the cost of the coverage for benefits. GT will provide you with information showing the current costs for your benefits during enrollment.

Your contributions for your portion of the cost of benefits may be deducted from your regular paycheck on a pre-tax basis through the Cafeteria Plan. That means you will most likely pay less in taxes since part of your pay is being deducted for the cost of your coverage before the whole paycheck is taxed. The full cost of coverage for covered family members who are not your tax dependents (e.g., domestic partners) will be deducted from your paycheck on an after-tax basis.

The health care programs may also have deductibles, co-payments, and co-insurance and maximum out-of-pocket amounts that you must pay. Deductibles, co-payments, co-insurance and out-of-pocket limits may vary among the coverage options available under the component programs, among the different features of a single coverage option, among covered groups, or in any other manner described in the Program Materials.

IV. BENEFITS

Information regarding the benefits available under the Welfare Plan is described in the Program Materials which are a part of this SPD. This information is important. You should read it and make sure you understand it. The Program Materials contain a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits. For example, the Program Materials contain information regarding what is covered and not covered, when you must get approval before obtaining medical care, deductibles, copayments, coinsurance, annual out-of-pocket maximums, and other limits on specific benefits. The Program Materials also contain information on subrogation and rights of recovery when third parties have caused injuries or illnesses, coordination of benefits, or there are other individuals, entities, plans, programs or insurance that may be responsible for providing you benefits.

V. FLEXIBLE SPENDING ACCOUNTS

GT offers two types of flexible spending accounts: Health FSA and Dependent Care FSA. Each is a bookkeeping account that allows you to set aside part of your salary on a pre-tax basis (before

income and employment taxes are calculated) to be used for eligible expenses. The Health FSA covers eligible health care expenses for you and your tax dependents (e.g. your spouse, children, and domestic partner if they qualify as a tax dependent). The Plan offers a Standard Health FSA or a Limited Purpose/Post Deductible Health FSA. If you are enrolled in the GT HDHP and make or receive contributions to an HSA you may only enroll in the Limited Purpose/Post Deductible Health FSA. The Dependent Care FSA covers eligible dependent care expenses.

Health Care Flexible Spending Account.

If you are an eligible employee you may elect to enroll in either the Standard Health FSA or the Limited Purpose/Post Deductible Health FSA. You may **not** enroll in the Standard Health FSA if you are enrolled in a HDHP and make, or receive contributions to an HSA. If you elect to contribute to either of the Health FSAs, you may contribute up to a maximum of \$3,200 in 2024 (adjusted for inflation) on a pre-tax basis. You will then be entitled to receive reimbursement for eligible health care expenses which are incurred while you are a participant in the Welfare Plan by you and your eligible dependents up to the total dollar amount you elected for the Plan Year, less any prior reimbursements made for that Plan Year. The expense must be incurred and the services performed before you may submit the expense for reimbursement. Note: “incurred” means an expense is incurred when you are provided with the health care that gives rise to the health expenses, and not when you are formally billed or charged for, or pay for the health care.

Eligible Health Care Expenses. With respect to the Standard Health FSA, eligible health care expenses include deductibles, copayments, dental and orthodontia expenses, prescription and over the counter drugs and medications, insulin, eye care, hearing care, menstrual care products, routine physical examinations, and any other medical care item which constitutes “medical care” under Section 213 and 223(d)(2) of the Internal Revenue Code. With respect to the Limited Purpose/Post Deductible Health FSA, eligible health care expenses include dental and vision care, and medical care expenses incurred after the specified medical deductible is met. Expenses reimbursed from your Health FSA cannot be deducted on your income tax return, and you cannot be reimbursed for expenses for which you have been reimbursed or which are reimbursable under any other health program. For example, the same eligible health care expenses may not be reimbursed from both a Health FSA and an HSA.

In all instances, the health care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Amounts for cosmetic surgery are eligible expenses only if they are necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. Eligible health care expenses can include products as well as services.

Products and services for cosmetic purposes, even if prescribed by a doctor (such as hair growth and wrinkle treatments) are not eligible expenses. In addition, an expense is not eligible if it is not for health care, or if it is merely for the beneficial health of you and your eligible family members (for example, vitamins or nutritional supplements that are not taken to treat a specific medical condition). Per IRS regulations, health insurance premiums, administrative or membership fees for boutique or concierge medicine are not reimbursable under the Health FSA.

Whether an expense is for health care as defined by Code Sections 213 and 223(d)(2) are within the sole discretion of the Administrator.

Timing for Incurring Expenses. Eligible health care expenses must be incurred during the Plan Year.

Reimbursement Procedures. Your claims for reimbursement will be made in accordance with a process set forth by the Contract Administrator (listed in the General Plan Information at the end of this SPD or by using your debit card, in accordance with procedures established by the Contract Administrator). Claims incurred during the Plan Year should be submitted within a reasonable time of incurring the expense, but in no event later than March 31st following the end of the Plan Year.

Debit Card. When you enroll, you will automatically be sent a Health FSA debit card the Contract Administrator within a few weeks. You may request additional cards for use by your spouse or eligible dependents (check with the Contract Administrator for details). Use of the card verifies your acceptance of the “terms & conditions” for use as specified by the Contract Administrator. You will be provided with instructions on how to activate and use your card. Be sure to keep your receipts for any services or products purchased with each card issued for your Health FSA.

You may be required to submit a detailed receipt (not the credit card like receipt, but one that describes the product or service paid for to show that the card was used for eligible expenses). If you are not able to show the card was used for eligible expenses, you will be required to repay Standard or Limited Purpose/Post Deductible Health FSA in the amount of the card transaction. If you fail to repay the Standard or Limited Purpose/Post Deductible Health FSA for non-eligible expenses, collection of past due amounts will be deducted from future reimbursements and/or be subject to other collection policies. Card privileges may be revoked at any time. Use of the card that exceeds the amount elected less amounts previously paid is your responsibility and must be paid back to the Cafeteria Plan.

Carryover. If you were a participant on the last day of the preceding Plan Year and have unused amounts in your Health FSA from the immediately preceding Plan Year, you may carryover unused amounts up to a maximum of \$640 in 2024 (subject to future cost of living increases). Any unused amounts in excess of the maximum carryover amount will be forfeited. The carryover funds may be used to reimburse eligible health care expenses during the entire Plan Year to which they have been carried over to.

If you will have a HSA for the upcoming year and have unused amounts, as of December 31st of the year prior, in your Standard Health FSA, those unused amounts will automatically (up to a maximum carryover of \$640 in 2024) carryover from the Standard Health FSA and transfer to a Limited Purpose/Post Deductible Health FSA. Only expenses that constitute eligible health care expenses with respect to the Limited Purpose/Post Deductible Health FSA will be paid or reimbursed from such unused amounts carried over from your prior year Standard Health FSA.

Forfeiture. If there is more than \$640 in your Health FSA as of the end of claims run out period (March 31st) following the end of the 2024 Plan Year, IRS rules require that the money in your account be forfeited. In general, forfeited amounts will be used to pay Plan administrative costs. For this reason, **you need to make careful estimates of your reimbursable expenses for the coming Plan Year when you make your Health FSA election.** As noted above, you have until March 31st following the end of the Plan Year in which to file claims for expenses incurred during the Plan Year.

Dependent Care Flexible Spending Account.

You may elect to contribute up to the lesser of your “earned income” or \$5,000 (\$2,500 if you are married and filing separately) on a pre-tax basis to the Dependent Care FSA (your “earned income” is the lesser of your earnings or your spouse’s actual or deemed earnings). You will then be entitled to receive reimbursement for employment-related dependent care expenses, which enable you and your spouse, if applicable, to work (or to actively seek work) or your spouse to attend school full-time. Employment-related dependent care expenses are incurred after your election date, but during the Plan Year, up to the current balance in your Dependent Care FSA. **Note: “incurred” means an expense is incurred when you are provided with the dependent care services and not when you are formally billed or charged for the dependent care services.**

If you are married, your spouse must work or be a full-time student for at least 5 months during the year while you are working, or be physically or mentally unable to care for themselves. If you are divorced or legally separated, you must have custody of your child most of the time even though your former spouse may claim the child for income tax purposes. If your spouse is a full-time student or is physically or mentally incapable of caring for themselves, they will be deemed to be earning \$250 per month (if you receive care for one dependent) or \$500 per month (for two or more dependents).

Qualifying Dependents. You may receive reimbursement for employment-related dependent care expenses for the care of “qualifying dependents.” Qualifying dependents are children under age 13 (through the day before they turn 13) whom you claim as dependents for income tax purposes, or your spouse or other dependent who is physically or mentally unable to care for themselves (even if you cannot claim an exemption for the person for income tax purposes) and who lives with you for at least half of the year. You may also claim dependent care expenses for the care of an elderly parent who spends at least 8 hours a day in your home and whom you can claim as a tax dependent.

Eligible Dependent Care Expenses. You may be reimbursed for care provided inside or outside your home by anyone **other than** your spouse, your child under age 19, and/or any person you claim as a dependent for income tax purposes. If the care is outside your home, it must be provided for your dependent who is under age 13 and whom you claim as a dependent on your tax return or for another “qualifying dependent” who regularly spends at least 8 hours per day in your household. If the expenses are incurred for services provided by a dependent care center (a facility that provides care for a fee and cares for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local licensing and other legal requirements.

Reimbursement Procedures. Your claims for reimbursement will be made online or on forms provided by the Contract Administrator in accordance with procedures established by the Contract Administrator. Claims incurred during the Plan Year should be submitted within a reasonable time of incurring the expense, but in no event later than March 31st following the end of the Plan Year.

If you fail to submit a claim within the period specified above, the claim shall not be considered for reimbursement by the Contract Administrator. No reimbursement will be made for amounts that exceed the balance in your Dependent Care FSA at the time reimbursement is requested. The amount of any eligible expenses not reimbursed will be carried over to subsequent months during the same Plan Year and reimbursed when the balance in your account permits.

Forfeiture. If there is money in your account at the end of the Plan Year and you have no more reimbursable expenses, IRS rules require that the money in your account be forfeited. In general, forfeited amounts will be used to pay Plan administrative costs or returned to GT. For this reason, **you need to make careful estimates of your reimbursable expenses for the coming Plan Year when you make your Dependent Care FSA election.**

Dependent Care FSA v. Tax Credit. Your individual circumstances and income will determine whether the federal, state (where eligible) and Social Security tax savings under the Dependent Care FSA provide greater tax benefits than using the federal tax credit. Contributions to the Dependent Care FSA reduce your federal tax credit availability. Since individual tax situations vary, it is important for you to select which approach offers more favorable tax savings. Regardless of whether you choose to enroll in the Dependent Care FSA or claim the federal tax credit, you must submit IRS Form 2441 along with your personal annual income tax filing. Please seek professional tax advice with any questions you may have regarding your individual tax situation.

Termination of Employment or Loss of Eligibility. If you terminate employment or cease to be an eligible employee (for instance, due to a reduction of hours), you may receive reimbursement for any allowable employment-related dependent care expenses incurred through the end of the Plan Year in which you ceased to participate in the Cafeteria Plan, up to the amount in your Dependent Care FSA as of the date you ceased to participate.

VI. HEALTH SAVINGS ACCOUNT

If you enroll in the GT HDHP and do not have coverage under another “impermissible plan” (e.g., a traditional plan of your spouse, individual health insurance, Medicare, or a standard health FSA) you are eligible to establish an HSA. An HSA is a custodial account, in your name, set up at the financial institution listed at the end of this SPD.

If you are eligible, you can make pre-tax payroll contributions to your HSA, which do not exceed the maximum statutory limits. You are responsible for ensuring that contributions to your HSA stay within the applicable IRS limits under Internal Revenue Code Section 223, requesting any

distributions if the limits are exceeded and addressing any tax consequences related to exceeding the maximum limits.

Your HSA account can be invested and grow (once you reach a certain balance) or can be used, tax-free, for out-of-pocket eligible medical expenses (such as copays and deductibles). If you are enrolled in the GT HDHP and establish and contribute to an HSA you may not enroll in the Standard Health FSA but you may enroll in the Limited Purpose/Post Deductible Health FSA.

Your HSA (which is separate from the Cafeteria Plan) belongs to you and cannot be forfeited, although there may be adverse tax consequences if contributions to your HSA or distributions from your HSA do not comply with IRS requirements. Check with your personal tax advisor if you have questions about your personal situation. For more information about the HSA, contact the Contract Administrator listed in the General Plan Information at the end of this SPD.

VII. SPECIAL PROVISIONS REGARDING HEALTH BENEFITS

Newborn's and Mother's Health Protection Act. The underlying health care programs may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, this does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Limits, deductibles, copayments, and coinsurance apply to these benefits.

Mental Health Parity and Addiction Equity Act. Any health care program, which provides both medical/surgical benefits and mental health or substance use disorder benefits, shall provide parity between the medical/surgical benefits and the mental health or substance use disorder benefits. This means that the same financial requirements (e.g. deductibles, co-payments, co-insurance, out-of-pocket maximums and any annual or lifetime limits) as well as quantitative treatment limitations (such as the number of treatments, visits or days of coverage) will be the same for medical/surgical benefits and mental health or substance use disorder benefits. Non-quantitative treatment limits, such as medical management standards, are also the same. For more information see the Program Materials.

Genetic Information Nondiscrimination Act. The health care programs of the Welfare Plan are prohibited from (i) adjusting group premiums or contribution amounts based on genetic information; (ii) requesting or requiring an individual or an individual's family members to undergo genetic testing; or (iii) requesting, requiring or purchasing genetic information for underwriting purposes. The HIPAA privacy rules (described below) also prohibit the use or disclosure of genetic information for underwriting purposes. The health care programs are designed to meet these requirements. For more information see the Program Materials.

Medicaid and the Children's Health Insurance Program (CHIP). If you are eligible for health care coverage but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you, your spouse, children or dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. You can contact the U.S. Department of Labor, Employee Benefits Security Administration at www.dol.gov/ebsa or 1-866-444-EBSA (3272), or the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services at www.cms.gov or 1-877-267-2323 to get a list of states that provide premium assistance (you are also provided this notice annually). If you, your spouse, children or dependents are not currently enrolled in Medicaid or CHIP and you think you might be eligible, you can contact your state Medicaid or CHIP office or call 1-877-KIDS-NOW (1-877-543-7669) or go to www.insurekidsnow.gov for further information.

If you, your spouse, children or dependents are eligible for premium assistance under Medicaid or CHIP, and if you are not already enrolled, you are entitled special enrollment rights described in the Special Enrollment section above.

Affordable Care Act. Under the Affordable Care Act you can cover your adult children through the end of the year when they attain age 26. You do not need prior authorization to obtain in network OB/GYN services. If your medical coverage requires you to designate a primary care physician you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children. You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same co-payments and deductibles. Your medical coverage cannot be retroactively cancelled, unless you fail to timely pay premiums, commit intentional misrepresentation or fraud. In other circumstances, you will generally be provided advance notice of cancellation. There are no pre-existing condition exclusions and no annual or lifetime limits. You are not required to pay a co-payment or other cost-sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information). You may be entitled to external review of certain health care claims. More detailed information may be found in the Program Materials.

No Surprises Act. The No Surprises Act prohibits balance billing for patients who unknowingly receive care from an out-of-network provider. Where certain conditions and notice criteria are met, out-of-network providers have the right to bill you for amounts over the allowed

amount, except for emergency services, air ambulance, and when prohibited by federal law, such as when an out-of-network provider is providing in-network services. There are external review rights associated with protections established by the No Surprises Act.

Qualified Medical Child Support Orders (QMCSO). The health care components of the Welfare Plan will provide benefits as required by any qualified medical child support order as defined in ERISA Section 609(a), or any National Medical Support Notice. For a copy of the Plans' QMCSO procedures, please contact the Plan Administrator listed in the General Plan Information section. The health care programs will also provide benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children, in accordance with ERISA Section 609(c).

Continuation of Benefits During Leave. If you go on a leave of absence and are receiving pay directly from GT (e.g. paid time off), your elections and salary reduction contributions shall continue in the normal course in accordance with the elections you made.

If you go on a leave where you are not receiving pay directly from GT (e.g. unpaid leave or you are receiving disability benefits from a third party), GT will continue your health coverage for the time period required under the Family and Medical Leave Act (FMLA) or for such longer period as provided in GT's leave of absence policy (as updated from time to time). Subject to any rights under the FMLA, you are responsible for paying your portion of salary reduction contributions in accordance with the terms of GT's leave of absence policies.

Should you fail to pay your portion of the salary reduction contributions or not return to employment, GT is entitled to recover any contributions which GT has paid on your behalf while you were on an unpaid leave.

While on leave, you have the same rights regarding open enrollment and status change election modifications as those employees participating in the Welfare Plan and the Cafeteria Plan who are not on leave.

Continuation of Benefits for Military Leave. You have certain rights and obligations under a Federal law commonly known as USERRA when you go on a military leave that is subject to USERRA, for a period of more than thirty-one (31) days. This includes the right to continue health care coverage for up to 24 months. You also have certain reinstatement rights upon your return from a military leave covered by USERRA. If the leave extends beyond thirty-one (31) days, you will have the opportunity to continue coverage at your expense (similar to COBRA), pursuant to the applicable military leave laws. For more information about your rights and obligations under USERRA please contact HRBenefits@gtlaw.com.

COBRA Continuation Coverage. COBRA is a federal law that requires eligible employees and dependents enrolled in the health care component programs of the Welfare Plan to be permitted to continue their group health plan coverage on a temporary basis in certain instances where coverage would otherwise end.

Qualified Beneficiaries. If you are an employee, you may elect COBRA coverage if you lose your coverage because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you may elect COBRA coverage if you lose your coverage because any of the following qualifying events happens:

- 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;
- Your spouse becomes entitled to Medicare benefits; or
- You become divorced or legally separated from your spouse.

Your dependent children may elect COBRA coverage if they lose coverage because any of the following qualifying events happens:

- 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;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage.

Domestic partners are not qualified beneficiaries under Federal law. Therefore, domestic partners are not individually entitled to elect COBRA continuation coverage. However, the GT health care programs extend COBRA like coverage to domestic partners.

Duration of Continuation Coverage. The following events will create a right to elect continued coverage under COBRA for the period indicated if the event causes the person to lose coverage:

18-month events. The following events will entitle you, your covered spouse, and your covered dependents to 18 months of continued coverage:

- Any voluntary or involuntary termination of employment other than for gross misconduct.
- Reduction in hours to below the hours required for participation in the health care components of the Welfare Plan.

29-month event. If you or your covered dependent is disabled (according to Social Security) at the time of or within 60 days after the COBRA qualifying event (termination of employment or reduction in hours) and if notice of the Social Security disability award is provided in writing to the Plan Administrator within 18 months of the qualifying event and within 60 days of the date of the award, then you and your covered dependents are entitled to 29 months of coverage. If you don't give this notice, you will lose your right to continued coverage.

36-month events. The following events will entitle your covered dependent(s) to 36 months of continued coverage:

- Divorce or legal separation, if you notify the Plan Administrator in writing within 60 days of the later of the event or the date coverage ends due to the event.
- Dependent child no longer eligible, if you notify the Plan Administrator in writing within 60 days of the later of the event or the date coverage ends due to the event.
- Employee dies.
- Employee enrolls in Medicare.

When a 36-month event occurs during the period of continuation coverage for an 18-month event (or a 29-month event), your dependents' coverage will be extended to 36 months from the original qualifying event date. If this happens, you must notify the Plan Administrator in writing within 60 days of the second event, or your covered dependents will not be entitled to COBRA beyond the initial 18 (or 29) month period.

Also, if you enroll in Medicare while an active employee and then you terminate employment or reduce your hours within 18 months after enrolling in Medicare, your covered dependents are entitled to 36 months of continued coverage measured from the date you enrolled in Medicare.

Note: With respect to the Health FSA, COBRA coverage continues until the end of the year in which you had a qualifying event.

Children Born or Acquired During COBRA Continuation Coverage. If you acquire a new dependent by birth, adoption, or placement for adoption during your COBRA continuation period, the child may be enrolled immediately for COBRA continuation coverage and the child has the same rights during the open enrollment period as any other person in the family who has COBRA continuation coverage. The maximum COBRA continuation coverage period for the child is the same as the maximum period that applies to other members of the family. It is not measured from the date of the birth, adoption, or placement for adoption. You must notify the COBRA Administrator within 30 days of the birth, adoption or placement for adoption.

Termination of COBRA Continuation Coverage. Your COBRA continuation coverage will terminate on the earliest of the following:

- The last day of the last month of the applicable 18, 29, or 36 month period, except in the case of divorce or legal separation where coverage will end 36 months after the date of the divorce or legal separation decree.
- The end of the year for the Health FSA.
- The end of the period for which the person continuing coverage timely made the required full cost of coverage or payment (non-payment).
- The date the person continuing coverage first becomes covered under another group health plan after electing COBRA continuation coverage. You must notify the COBRA Administrator in writing within 30 days of becoming covered under the other plan.

- The date the person continuing coverage first enrolls in Medicare after electing COBRA continuation coverage. You must notify the COBRA Administrator in writing within 30 days of becoming covered under Medicare.
- The date GT (and its related companies) discontinues all group health plans offered to any similarly situated active employees.
- If coverage is being continued due to disability (months 19 through 29), the first day of the month that is more than 30 days following the date the Social Security Administration determines that the person is no longer disabled. For example, if the Social Security Administration determines you stopped being disabled on January 15, your disability extension will end on March 1. If the Social Security Administration determines that the disability has stopped, you must notify the COBRA Administrator in writing within 30 days of the date of the final determination.

Cost of COBRA Continuation Coverage. If you or your dependents choose to continue coverage, you will be required to pay the full cost of the coverage, plus 2% for administration. However, if you or your covered dependent is entitled to 29 months of extended coverage due to disability, you may be required to pay 150% of the designated cost after the first 18 months of coverage. The COBRA Administrator can provide you with information on the cost of continuation coverage.

How to Apply For COBRA Continuation Coverage. It is GT's responsibility to notify the COBRA Administrator of your reduction in work hours, death, or your becoming eligible for Medicare. However, you are responsible for notifying GT in writing within 60 days in the event of a divorce, legal separation, or your child's loss of dependent status, using the procedures specified below.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must provide notice to GT by logging in to [GT Workday \(https://www.myworkday.com/gtlaw\)](https://www.myworkday.com/gtlaw) and entering information about the event permitting the change and providing supporting documentation. If you need assistance providing notice through GT Workday, you may contact hrbenadmin@gtlaw.com.

Be aware that there are other notice requirements in other contexts, for example, to qualify for a disability extension.

Once the COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each eligible person. The COBRA Administrator will provide the eligible person with the necessary application and information to enroll for continued coverage through COBRA. Evidence of good health is not required to obtain continuation coverage. The eligible person will have 60 days from the time coverage stops or the date a COBRA notice is sent (whichever is later) to enroll for COBRA coverage.

Each eligible person has the right to make a separate, individual election. The covered employee may elect COBRA continuation coverage for his or her spouse and a parent may elect COBRA continuation coverage on behalf of his or her children. For each eligible person who elects continuation coverage, coverage will begin on the date the health care coverage under the Welfare Plan would otherwise have been lost. If you, your spouse, or your dependents do not enroll for continuation of coverage within the 60 day period, you lose the opportunity to do so.

Paying For COBRA Continuation Coverage. If you or your dependent elect continued coverage, payment of all contributions due must be made within 45 days of the date the election form was signed to continue coverage. Subsequent COBRA payments will be due on a monthly basis on the first day of the month of coverage. However, you will be given a grace period until the 30th day of the month for which it is due to make each periodic payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the health care components of the Welfare Plan. It will be the sole responsibility of the individual to make timely payment of contributions.

Applying for the Disability Extension. To extend your coverage beyond the 18-month period, you must provide a letter of determination to the COBRA Administrator showing that you are entitled to Social Security disability benefits. You must provide this information in writing within 60 days of its receipt and before the end of the 18-month COBRA continuation period or you will not be allowed to extend your COBRA coverage.

If the Social Security Administration determines that the disability has stopped, you must notify the COBRA Administrator in writing within 30 days of the date of the determination.

Privacy of Health Information. HIPAA requires the health care programs (medical and prescription drug, dental, vision, EAP, and health FSA) to safeguard the privacy of your Protected Health Information (“PHI”). However, as explained below, the health care programs may use and disclose PHI, including your PHI, in some cases.

PHI is data about a past, present or future physical or medical condition, treatment received, or payment for health care that also identifies the person it relates to. The health care programs are allowed to use or disclose PHI for a variety of reasons, including, but not limited to, for treatment, payment and health care operations, pursuant to your authorization, for public health purposes, to GT as the Plan Sponsor for its administrative purposes, as required by law, and as described in the *HIPAA Privacy Notice*.

Participants and their covered eligible dependents will have the rights set forth in the *HIPAA Privacy Notice* and any other rights and protections required under HIPAA. The Notice may periodically be revised. To receive more information about the privacy practices or your rights, or to request a copy of the *HIPAA Privacy Notice*, you may contact:

HR Benefits Department
c/o Greenberg Traurig, P.A.
8400 N.W. 36th Street

Suite 400
Doral, FL 33166
305-418-6200
hrbenefits@gtlaw.com

The *HIPAA Privacy Notice* is also available on the GT Intranet.

The health care components of the Welfare Plan have established a complaint procedure concerning the handling of PHI. The *HIPAA Privacy Notice* explains the complaint procedure. All complaints or issues raised by participants or their covered eligible dependents with respect to the use of their PHI must be submitted in writing to the Privacy Official at:

HR Benefits Department
c/o Greenberg Traurig, P.A.
8400 N.W. 36th Street
Suite 400
Doral, FL 33166
hrbenefits@gtlaw.com

A response will be made within a reasonable period of time, including time to investigate and resolve any issues, after the receipt of the written complaint. The Privacy Official shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Official shall be final and be given full deference by all parties.

VIII. AMENDMENT OR TERMINATION OF THE PLAN

GT reserves the right to amend the Welfare Plan and the Cafeteria Plan, any component program, in whole or in part at any time. GT reserves the right to change or cancel the Plans, any component program, or any benefits under the Plans, at any time. If GT cancels the Plans, any component program or any benefits under the Plans, participation in the canceled benefits terminates on the date of cancellation. However, no amendment or termination will affect your right to any unpaid benefit under the Plans or component program, if you have satisfied all the requirements to receive a benefit under the Plans or component program. Participation in the Plans or component program does not give you any rights to continuing employment.

IX. COST OF COVERAGE AND FUNDING

Cost of Coverage and Payment for Coverage. You and GT share the cost of coverage for the component programs that you select. The amount of employer contributions and employee contributions are determined by GT in its sole and absolute discretion. Employer contributions may be paid directly to the insurance company or other provider and shall be applied toward the cost of benefits. With respect to any self-funded benefits, which are payable out of GT's (or related employer's) general assets, GT will use employee contributions first and then use employer contributions to pay such benefits directly on behalf of you and your covered family members.

The dollar amount of the required employee contributions is determined from time to time by GT, in its sole discretion, and is set forth in the latest enrollment materials provided to you. GT may require different contribution levels for different classes of employees and may increase or decrease the amount of required contributions. You will be notified during enrollment of the amount of employee contributions for each benefit. Employee contributions are collected through payroll deductions through the Cafeteria Plan or applied directly to the payment of premiums. Employee contributions for your share of the cost of benefits may be made on a pre-tax basis for you, your spouse and eligible dependents through the Cafeteria Plan. Coverage for individuals who are not your tax dependents must be paid after-tax.

Please note that GT also establishes (i) any amount that must be paid by you as a deductible before component programs will reimburse you for expenses that otherwise would be eligible for benefits, (ii) any co-payment or co-insurance which must be paid by you to a provider at the time services are received under a coverage option, and (iii) any maximum out-of-pocket amount that you must pay during any one Plan Year. Deductibles, co-payments or co-insurance and out-of-pocket limits may vary among the coverage options available under the component programs, among the different features of a single coverage option, among covered groups, or in any other manner determined in the discretion of GT and described in the Program Materials.

Source of Benefit Payments. The source of funding for the payment of Welfare Plan benefits is determined by GT in its sole and absolute discretion. The funding policy for any component program may call for GT to purchase and hold insurance contracts and policies to provide some or all of the benefits, for all or a part of the benefits provided to be paid from the general assets of GT (or related employer), or for all or part of the benefits provided to be funded by participant contributions. The funding policy of any component program may be amended in writing by GT or its authorized delegate from time to time.

Insured and Contractual Benefits. With regard to the insured and contractual benefits, nothing obligates GT (or any related employer) beyond the obligation to make premium payments as provided by the applicable contracts. GT (nor any related employer) does not guarantee benefits payable under any insurance policy or other contract, and any benefits under an insurance policy or other contract will be the exclusive responsibility of the insurer or other entity that is required to provide benefits under that policy or contract.

Self-Funded Benefits. With regard to unfunded benefits, which are payable out of the general assets of GT (or related employer), nothing will be construed to require GT, any related employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any participant (or covered family member).

No Rights to Assets. No employee, participant, covered family member or other party shall have any right to, security or other interests in, or claim against any particular assets of GT, any related employer, the Welfare Plan or Cafeteria Plan, any component program, or any underlying contract, trust, or other vehicle.

Payment of Administrative Expenses. All reasonable expenses incurred in administering the Welfare Plan and the Cafeteria Plan, including, but not limited to, administrative fees and expenses owing to any administrative service provider, actuary, consultant, accountant, specialist

or other person or organization that may be employed in connection with Plan administration, shall be paid by the Plans, including, to the extent permitted by applicable law, by any forfeitures, unless paid by GT or a related employer.

X. CLAIMS PROCEDURE

Filing Claims. The claims procedures described below are representative of the actual claims procedures followed by the applicable Claims Administrator. We are required to describe the ERISA required claims provided in this SPD. The Program Materials explain the specific procedures you must follow in claiming benefits under that program. The third party administrators listed in Section XIII are the Claims Administrators for the self-insured health plans, and the HMO or insurance companies are the Claims Administrators with respect to the insured benefits. They are referred to as the “Claims Administrator” in this section. You must follow the claims procedures of the Claims Administrators, which may require you to complete, sign and submit a written claim on the Claims Administrator’s form. You should consult the Program Materials for the details on filing a claim and appealing claims that are denied.

Distributions from your HSA (whether before or after cessation of participation) and all other matters relating to your HSA are outside of the Welfare Plan and Cafeteria Plan and are governed by the agreement between you and the HSA custodian. The Dependent Care FSA and your HSA are not subject to ERISA. However, for administrative convenience the Dependent Care FSA administrator generally follows the “post-service” claims procedures time frame that applies to the Health FSA (i.e., the post-service medical claims procedures), which is described in the Health Care Claims Section. Even if the Claims Administrator follows the procedures set forth below, no one (not you, your spouse, dependents, or other party) may rely on, or assert a violation based on the Claims Administrator’s failure to follow the claims procedures set forth below, with respect to the Dependent Care FSA.

For purposes of determining the entitlement to benefits under each component program, the respective Claims Administrator is the “named fiduciary” with the full power and authority to interpret and apply the terms of the Welfare Plan and Cafeteria Plan as they relate to the benefits provided under the applicable insurance contract or component program. The decisions of the Claims Administrator are binding.

A “claim” is defined as any request for a Plan benefit made by you, a covered spouse or dependent, or a beneficiary (a “claimant”), or by an authorized representative of a claimant, that complies with Plan procedures for making a benefit claim. There are different types of claims (health, disability, and other benefits) and each one has a specific timetable for approval, payment, request for further information, or denial of the claim.

With respect to those component programs that are subject to ERISA, the Claims Administrator will decide the claim in accordance with its reasonable claims procedures, as required by ERISA. If the Claims Administrator denies a claim in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the denial. You must appeal the denial within certain timeframes. The Claims Administrator will decide the appeal in accordance with its reasonable claims procedures, as

required by ERISA, and provide you written notification of its decision. There may be voluntary levels of appeal and for medical benefits, and under certain circumstances you may have the right to obtain external review (that is, review outside the Welfare Plan).

Disability, Life and AD&D Claims. The claims procedures outlined below are representative of the actual claims procedures followed by the Claims Administrator of the disability, life and AD&D component programs of the Welfare Plan.

Filing a Claim. You must follow the claims procedures established by the applicable Claims Administrator. If you are required to file an initial claim for benefits, you must do so within the time specified in the Program Materials. See Section XIII for contact information for the Claims Administrators.

Decision on a Claim.

With respect to disability claims. In the case of a claim for disability benefits under the Welfare Plan, the Claims Administrator will notify the claimant or claimant's authorized representative of its benefit determination not later than 45 days after receipt of the claim. This period may be extended by the Claims Administrator for up to 30 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. This 75-day period (original 45-day period plus first 30-day extension) for making the benefit determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant or authorized representative (before the end of the first 30-day extension period) of the circumstances requiring the additional extension and the date by which the Claims Administrator expects to make its benefit determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

With respect to life and AD&D claims. In the case of a claim for life or AD&D benefits, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 90 days after receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 90 days, provided that (i) the Claims Administrator determines that special circumstances require an extension of time for processing the claim, and (ii) written notice of the extension is furnished to the claimant or authorized representative before the end of the initial 90-day period. The notice of extension will indicate the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination.

With respect to disability, life, and AD&D claims, if the claim is denied (in whole or in part), the Claims Administrator will provide the claimant or authorized representative

with written notification of the adverse benefit determination. The notification will set forth, in a manner calculated to be understood by the claimant or authorized representative (and for disability claims, in a culturally and linguistically appropriate manner):

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant or authorized representative to perfect the claim, and an explanation of why such material or information is necessary; and
- A description of the Claims Administrator's review procedures and the time limits applicable to such procedures (including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review).

With respect to disability claims, the notification will also set forth:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Welfare Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Welfare Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Welfare Plan made by the Social Security Administration.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Welfare Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Welfare Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Welfare Plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records, and other information relevant to the claimant's claim for benefits.

Appeal of Adverse Decision. If you disagree with the decision on your claims, you or your authorized representative may file a written appeal with the applicable Claims Administrator. For a list of Claims Administrators see Section XIII.

With respect to disability claims, you must submit an appeal, in writing, to the Claims Administrator within 180 days following receipt by the claimant or authorized representative of an adverse benefit determination.

With respect to life and AD&D claims, you must submit an appeal, in writing, to the Claims Administrator within 60 days following receipt by the claimant or authorized representative of an adverse benefit determination.

With respect to disability, life and AD&D claims, the claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits. The Claims Administrator's review of the adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

With respect to disability claims, the Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination. In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment, the individual conducting the Claims Administrator's review will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

Before the Welfare Plan can issue an adverse benefit determination the Plan administrator has to provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination in connection with the claim as soon as possible and sufficiently in advance of the date on which the adverse benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond. Before the Welfare Plan can issue an adverse benefit determination on a new or additional rationale, the Plan Administrator also has to provide the claimant, free of charge, with the rationale, sufficiently in advance of the date on which the adverse benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond.

Notification on Appeal. The Claims Administrator will notify the claimant or authorized representative of its decision on appeal in writing in accordance with the time frames and procedures described below.

With respect to disability claims, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination on review

within 45 days after receipt of a timely appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the appeal. If the Claims Administrator determines that an extension of time for processing the appeal is required, written notice of the extension will be sent to the claimant or authorized representative before the end of the initial 45-day period. In no event will the extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to make its benefit determination on review.

With respect to life and AD&D claims, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination on review within 60 days after receipt of a timely appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the appeal. If the Claims Administrator determines that an extension of time for processing the appeal is required, written notice of the extension will be sent to the claimant or authorized representative before the end of the initial 60-day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to make its benefit determination on review.

With respect to disability, life and AD&D claims, the Claims Administrator's benefit determination on review will be provided in writing to the claimant or authorized representative. In the case of an adverse benefit determination on review, the notification will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the adverse benefit determination on review;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A statement that the claimant or authorized representative 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 for benefits; and
- A statement describing any voluntary appeal procedures offered by the Welfare Plan, and a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

With respect to disability claims, the notification will also set forth a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Welfare Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Welfare Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant made by the Social Security Administration and presented by the claimant to the Welfare Plan. The statement of the claimant's right to bring a civil action following an adverse benefit determination on review should describe any applicable contractual limitations period that applies to the claimant's right to bring

such an action, including the calendar date on which the contractual limitations period expires.

Health Care Claims. The claims procedures described in this section are representative of the actual claims procedures followed by the Claims Administrators for the health component programs (medical, prescription drug, vision, dental, Health FSA, and EAP). The Affordable Care Act added additional requirements related to internal claims and appeals as well as an external review process, which apply to the medical benefits under the Welfare Plan. ***This section does not describe all of the procedures applicable to claims under the medical benefits; see the Program Materials for more details and follow the procedures outlined in the health care Program Materials that you and your eligible dependents are covered under.*** The Health FSA is generally subject to the post-service claims procedures. Because the EAP provides services rather than reimbursement, there is no need to submit claims under the EAP. However, if you need to contact the EAP Administrator, see Section XIII.

Pre-Service and Post-Service Claims. A *pre-service claim* is any claim for a benefit that requires Claims Administrator approval in advance of obtaining medical care. A *post-service claim* is any claim for a benefit in which the medical care or treatment has already occurred.

In the case of a pre-service claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 15 days after the Claims Administrator's receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 15 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

In the case of a post-service claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 30 days after the Claims Administrator's receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 15 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

If the pre-service or post-service claim is denied (in whole or in part), the Claims Administrator will provide the claimant or authorized representative with written notification of the adverse benefit determination. A *written notification of an adverse benefit determination* will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant or authorized representative to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the Welfare Plan's review procedures and the time limits applicable to such procedures (including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review);
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request;
- If the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Welfare Plan to the claimant's medical circumstances) or a statement that such an explanation will be provided free of charge upon request.

The claimant or authorized representative may obtain a full and fair internal review by the Claims Administrator of the claim and adverse benefit determination by submitting an appeal to the Claims Administrator within 180 days following receipt by the claimant or authorized representative of an adverse benefit determination (whether the claim is a pre-service claim or post-service claim). The claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

The Claims Administrator's review of the adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any

medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination.

In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the individual conducting the Claims Administrator's review will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

In the case of a pre-service claim, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 30 days after receipt of a timely appeal if there is one level of appeal. If there are two levels of appeal the Claims Administrator will provide notification within 15 days after a timely filed first level appeal, with 60 days to file a second level appeal and notification within another 15 days after a timely filed second level appeal (see, e.g., the UHC SPD). In the case of a post-service claim, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 60 days if there is one level of appeal. If there are two levels of appeal the Claims Administrator will provide notification within 30 days after a timely filed first level appeal, with 60 days to file a second level appeal and notification within another 30 days after a timely filed second level appeal (see, e.g., the UHC SPD). The Claims Administrator's final internal benefit determination (for pre-service or post-service claims) will be provided in writing to the claimant or authorized representative. In the case of a *final internal adverse benefit determination*, the notification will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the final internal adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A statement that the claimant or authorized representative 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 for benefits;
- A statement describing the external appeal procedures offered by the Welfare Plan;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request; and

- If the final internal adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Welfare Plan to the claimant's medical circumstances) or a statement that such an explanation will be provided free of charge upon request.

Concurrent Claims. A *concurrent care claim* relates to the Claims Administrator's previous approval for an ongoing course of treatment to be provided over a period of time or number of treatments. The claims procedures for concurrent care claims are identical to the claims procedures set forth above for urgent care claims or pre-service claims, except as follows:

In the case of a concurrent care claim involving a reduction or termination by the Claims Administrator of a previously approved ongoing course of treatment (other than by Welfare Plan amendment or termination) before the end of the previously approved period of time or number of treatments, the reduction or termination will constitute an adverse benefit determination. The Claims Administrator will notify the claimant or claimant's authorized representative of this determination at a time sufficiently in advance of the reduction or termination to allow the claimant or authorized representative to file an appeal and obtain a review by the Claims Administrator of the adverse benefit determination before the benefit is reduced or terminated.

In the case of a concurrent care claim involving a request by a claimant or authorized representative to extend a previously approved ongoing course of treatment beyond the approved period of time or number of treatments, and that involves urgent care, the Claims Administrator will notify the claimant or authorized representative of the benefit determination within 24 hours after the Claims Administrator's receipt of the claim, provided that the claim is made to the Claims Administrator at least 24 hours before the end of the previously approved period of time or number of treatments.

If the request is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits as described below. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Urgent Care Claims. An *urgent care claim* is an oral or written request for medical care or treatment where a delay in the Claims Administrator's benefit determination could seriously jeopardize the claimant's life or health, or the claimant's ability to regain maximum function, or (in the opinion of a physician with knowledge of the claimant's medical condition) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of the Welfare Plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical

condition determines that the claim is an urgent care claim as described above, then the Claims Administrator will treat the claim as an urgent care claim.

In the case of an urgent care claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 72 hours after the Claims Administrator's receipt of the claim, unless the claimant or authorized representative fails to provide sufficient information to determine whether (or to what extent) benefits are covered or payable under the Welfare Plan. In the case of such a failure, the Claims Administrator will notify the claimant or authorized representative not later than 24 hours after the Claims Administrator's receipt of the claim, regarding the specific information necessary to complete the claim. The claimant or authorized representative will have 48 hours to provide the specified information. The Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information, or (ii) the end of the period given the claimant or authorized representative to provide the specified additional information.

The Claims Administrator will provide the initial benefit determination to the claimant or authorized representative in writing, or the information may be provided orally in the case of an adverse benefit determination. If the determination is provided orally, written notification will be sent no later than three days after the oral notification. Written notice of an initial benefit determination will include a description of the expedited review procedure applicable to urgent care claims (including the fact that all necessary information will be transmitted between the Claims Administrator and the claimant or authorized representative by telephone, facsimile, or other similarly expeditious method that is available).

The claimant or authorized representative may obtain a full and fair review by the Claims Administrator of the claim and adverse benefit determination by submitting an appeal (either orally or in writing) to the Claims Administrator on an expedited basis following receipt by the claimant or authorized representative of an adverse benefit determination. The claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

The Claims Administrator's review of the adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any medical or vocational expert whose advice was obtained in connection with the initial

adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination.

In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the individual conducting the Claims Administrator's review will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

The Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 72 hours after receipt of a timely appeal. The Claims Administrator's final internal benefit determination will be provided in writing to the claimant or authorized representative.

External Review Program for Medical Benefits. If, after exhausting your internal appeals (or as otherwise specifically noted below for ***expedited reviews***) you are not satisfied with the Claims Administrator's determination of your claim for medical benefits, you may be entitled to request an external review of the Claims Administrator's determination at no charge. You may request the external review by an Independent Review Organization (IRO) based on (i) medical judgment (including, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or exclusions for treatments that are experimental or investigational); (ii) rescission of coverage (coverage that was cancelled or discontinued retroactively); or (iii) as otherwise required by applicable law.

To request a *standard external review*, you or your representative should send a written request to the address set out in the adverse benefit determination letter. In urgent situations as detailed below, you or your representative should request an expedited external review by the number provided by the Claims Administrator or by sending a written request to the address set out in the adverse benefit determination letter. A request must be made within four months after the date you receive the Claims Administrator's final adverse decision on your internal claim/appeal. An external review request should include all of the following:

- a specific request for external review;
- your name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

Within five (5) business days after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted was covered under the Welfare Plan at the time the health care service or procedure that is at issue in the request was provided, has exhausted the applicable internal appeals process, and has provided all the information and forms required so that the Claims Administrator may process the request. The Claims Administrator will notify you within one (1) day of completing your preliminary review whether the request is eligible for external review by an IRO.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You should submit in writing any additional information that the IRO will consider when conducting the external review within ten (10) business days following the date of receipt of the notice. The IRO is not required to, but may, accept and consider additional information submitted by you after ten (10) business days. The Claims Administrator will provide to the assigned IRO all medical records, other documents, and other information or evidence that you or your physician submitted that the Claims Administrator considered in making its determination.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its Final External Review Decision within 45 days after it receives the request for external review (unless they request additional time and you agree). This notice will be delivered to you and the Claims Administrator and include the clinical basis for the determination. If the decision reverses the Claims Administrator's determination, the Welfare Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Welfare Plan.

An *expedited review* is similar to a standard external review, except the time periods for completing certain portions of the review process are much shorter, and in some instances, you have the right to file an expedited external review before completing the internal appeals process. You have the right to make a written or verbal request for an expedited external review if you receive: (1) an adverse benefit determination for a claim or appeal involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or the ability to regain maximum function and you have filed a request for an expedited internal appeal; or (2) a final appeal decision for a determination involving a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services, but you have not been discharged from a facility.

The Claims Administrator will determine immediately upon receipt of the request whether you were covered under the Welfare Plan at the time of the service or procedure at issue, and have provided all required information and forms. The Claims Administrator will immediately send a notice in writing to you upon completion of this review and follow the same procedures as with a standard external review. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as required,

but in no event more than 72 hours after receiving the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

Discretionary Authority. The Plan Administrator and Claims Administrator (with respect to the component program they insure and/or administer) have full discretionary authority to determine eligibility, status, and rights of all individuals under the Welfare Plan and the Cafeteria Plan and to construe any and all terms of the Plans.

No Transfer or Assignment of Benefits or Rights. None of the benefits, payments, proceeds, claims or any other rights afforded to you, a covered spouse or dependent or beneficiary under the Plans shall be subject to any claim or any creditor. In addition, you, your covered spouse or dependent, or beneficiary may not assign, alienate, anticipate, commute, pledge or encumber any benefits, payments, proceeds, claims or other rights which any of you may be entitled to receive or assert under the Plans, other than with the express written consent of the Plan Administrator (or third party administrator responsible for claims adjudication of a benefit program) or as expressly required by law.

Legal Action. Because the Welfare Plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the final appeal. However, you may not bring a legal action until 90 days after you have properly submitted a request for reimbursement and you have exhausted the Welfare Plan's claims and appeals procedures. In addition, you must bring a civil action within three years of receiving the final appeal decision or a shorter period set forth in the Program Materials.

XI. YOUR ERISA RIGHTS

As a participant in the Welfare Plan (the HSA and the Dependent Care FSA are not part of the Welfare Plan or subject to ERISA), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Welfare Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Welfare Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Welfare Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Welfare Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Welfare Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. You may be entitled to continue health care coverage for yourself, your spouse or your dependents if there is a loss of health care coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review the rules governing your COBRA continuation coverage rights in this SPD and the documents governing the Welfare Plan.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Welfare Plan. The people who operate the Welfare Plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other 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 benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a 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 Welfare Plan documents or the latest annual report from the Welfare Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Welfare Plan's claims and appeals procedures. In addition, if you disagree with the Welfare 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 the fiduciaries misuse the Welfare 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 the Welfare Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XII. GENERAL PLAN INFORMATION

Plan Sponsor: Greenberg Traurig, P.A.
8400 N.W. 36th Street
Suite 400
Doral, FL 33166
305-418-6200

Employer Identification Number: 59-1270754

Name of Plan: Greenberg Traurig, P.A. Welfare Benefit Plan (Note: certain provisions of the Greenberg Traurig, P.A. Cafeteria Plan, including the Dependent Care Flexible Spending Account and Health Savings Account are described in this SPD for the convenience of eligible employees but are not part of the Plan and are not subject to ERISA.)

Plan Number: 508

Plan Year: January 1 through December 31

Type of Plan: Health and welfare benefits

Source of Contributions: Employer and employee contributions

Funding Medium: Self-insurance and insurance

Type of Administration: Fully insured benefits are administered by insurance companies which are responsible for all claims and discretionary determinations and for making payments under the portions which they insure. The self-insured benefits are administered by third party administrators. The table at the end provides contact information for each third party administrator and insurance company.

Plan Administrator: Greenberg Traurig, P.A.
Attention: HR Benefits Department
8400 N.W. 36th Street
Suite 400
Doral, FL 33166
305-418-6200

Agent for Service of Process:

Greenberg Traurig, P.A.
Attention: HR Benefits Department
8400 N.W. 36th Street
Suite 400
Doral, FL 33166
305-418-6200

Legal process also may be served on the Plan Administrator.

XIII. THIRD PARTY ADMINISTRATORS AND INSURANCE COMPANIES

Type of Benefit:	The third party administrators and insurance companies are responsible for making all discretionary determinations and for making payments under the portions of the Plans which they administer or insure.
Medical and Prescription Drug	United Healthcare 866-734-7670 PO Box 1459 Minneapolis, MN 55440-1459 www.myuhc.com MVP (Albany Only) 888-687-6277 625 State Street Schenectady, NY 12305-2111 www.mvphealthcare.com/members CVS/Caremark 866-282-5526 One CVS Drive Woonsocket, RI www.caremark.com
Dental	Cigna 800-997-1654 900 Cottage Grove Road Bloomfield, CT 06002 www.cigna.com
Vision	United Healthcare 800-638-3120 PO Box 1459 Minneapolis, MN 55440-1459 www.myuhcvision.com
Life and Accidental Death and Dismemberment	Sun Life Assurance Company of Canada 800-247-6875 One Sun Life Executive Park Wellesley Hills, MA 02481-5699 www.sunlife.com

Long Term Disability	Sun Life Assurance Company of Canada 800-247-6875 One Sun Life Executive Park Wellesley Hills, MA 02481-5699 www.sunlife.com
Short Term Disability	Sun Life Assurance Company of Canada 800-247-6875 One Sun Life Executive Park Wellesley Hills, MA 02481-5699 www.sunlife.com
Employee Assistance Program	Optum 866-234-8913 13625 Technology Drive Eden Prairie, MN 55344 (866) 386-3404 www.liveandworkwell.com
Health FSA	HealthEquity/Wageworks 877-924-3967 15 W. Scenic Pointe Drive, Suite 100 Draper, UT 84020 www.healthequity.com
Dependent Care FSA (not subject to ERISA)	HealthEquity/Wageworks 877-924-3967 15 W. Scenic Pointe Drive, Suite 100 Draper, UT 84020 www.healthequity.com
Health Savings Account (not subject to ERISA)	OptumBank 866-234-8913 2525 S. Lake Park Blvd, #101 Salt Lake City, UT 84120 www.optumbank.com
COBRA Administrator	HealthEquity/Wageworks 888-678-4881 PO Box 223684 Dallas, TX 75222-3684 mybenefits.wageworks.com