

**Sprouts Farmers Markets Holdings, LLC
Employee Benefit Plan**

**Plan Document
and
Summary Plan Description**

Amended and Restated Effective July 1, 2019

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Introduction

Sprouts Farmers Markets Holdings, LLC (the “Company”) established this Sprouts Farmers Markets Holdings, LLC Employee Benefit Plan (the “Plan”) on August 1, 2002. The Plan is hereby amended and restated effective July 1, 2019. The Company is the Plan Administrator for this Plan.

This document, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, “Benefit Booklets”) which are hereby incorporated into this document by reference, is intended to serve as the Plan document and the Summary Plan Description (“SPD”), as required by the Employee Retirement Income Security Act of 1974 (“ERISA”).

The Plan provides the following benefits for eligible Plan participants and their eligible dependents:

- Medical (HMO, HDHP, PPO, and minimum essential coverage (MEC) Options)
- Dental PPO (Preferred and Basic Plan Options)
- Voluntary Vision (Plus and Basic Plan Options)
- Employee Assistance Plan (EAP)
- Short-Term Disability (STD) (Group and Voluntary Options)
- Long-Term Disability (LTD)
- Basic Life Insurance
- Supplemental Life Insurance
- Supplemental Dependent Life Insurance
- Basic Accidental Death and Dismemberment (AD&D)
- Voluntary AD&D
- Group Accident Insurance
- Group Critical Illness Insurance
- Group Hospital Indemnity
- Pre-paid Legal/ID
- My Wellbeing Program
- Pre-Tax Premium Payment
- Health Care Flexible Spending Account (“Health Care FSA”)
- Limited Purpose Health Care Flexible Spending Account (“Limited Purpose Health Care FSA”)
- Dependent Care Flexible Spending Account (“Dependent Care FSA”)
- Health Savings Account (HSA)

Certain benefits available under this Plan are intended to satisfy the requirements of Internal Revenue Code of 1986 (“Code”) Sections 125, 129, 105, and 106 to provide employees self-insured Medical benefits, Health Care and Dependent Care Flexible Spending Accounts, and the opportunity to make pre-tax contributions toward certain benefits. Employees enrolled in the high deductible health plan option under this Plan may make pre-tax contributions to a Health Savings Account (HSA).

The self-insured group health plan benefits provided under this Plan are intended to be nondiscriminatory under applicable provisions of the Code. If the Plan Administrator determines before or during any Plan Year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), the applicable provisions of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act (HCERA).

Some Plan benefits are provided under insurance or HMO contracts. Other benefits offered under the Plan are self-insured and are administered under contracts with service providers. All benefits are summarized in this document and in the Benefit Booklets.

This document should be read in conjunction with the Benefit Booklets. The Benefit Booklets are provided by the insurance companies, HMOs, and third party service providers. If there is ever a conflict or a difference between what is written in this document and the Benefit Booklets with respect to the specific benefits provided, the Benefit Booklets shall govern unless otherwise provided by any federal or state law. If there is a conflict between the Benefit Booklets and this document with respect to the legal compliance requirements of ERISA and any other federal law, this document will be considered the governing document.

The applicable Benefit Booklets describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you, upon request. You may also access provider directories on the insurance companies' and HMOs' websites, or you can call the insurance companies or HMOs at the phone numbers indicated in the Benefit Booklets. You will be informed about any conditions or limits on the selection of primary care providers or specialty Medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator or the applicable insurance carrier, HMO, or service provider identified in Appendix B.

The Company reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

No Guarantee of Tax Consequences

The Plan Administrator makes no commitment or guarantee that any amounts paid to or for the benefit of any person under this Plan will be excludable from gross income for federal, state, or local income tax purposes. It shall be the obligation of each person covered by a Plan benefit to determine whether each payment under this Plan is excludable from his or her gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if he or she has any reason to believe that such payment is not excludable.

Not a Contract of Employment

Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any employee. Nothing in this document or the Benefit Booklets gives any employee the right to be employed by the Company or to interfere with the Company's right to discharge any employee at any time.

Eligibility

Eligible Employees

Eligibility for benefits is based upon employment classification.

Group 1 Exempt: Group 1 Exempt includes all employees of the Company who are reasonably expected as of their hire date to work 28 or more hours per week and who are classified as exempt employees. Team members in Group 1 Exempt are eligible for Plan benefits on their date of hire.

Group 1 Nonexempt: Group 1 Nonexempt includes all employees of the Company who are reasonably expected as of their hire date to work 28 or more hours per week but who are **not** classified as exempt employees. Team members in Group 1 Nonexempt will be eligible for benefits on the first day of the month following 30 continuous days of employment.

Group 2: Group 2 includes all employees of the Company who are reasonably expected to work a varying number of hours each week as of their date of hire (sometimes referred to as “variable hour employees”) who are determined to have worked an average of 28 or more hours per week in accordance with the Look-Back Measurement Policy. See Appendix D “Look-Back Measurement Policy for Identifying Eligible Employees” for additional details. Team members in Group 2 will be eligible for benefits on the first of the month following the administrative period associated with the applicable measurement period in which the employee is determined to be full-time. Eligibility will continue through the corresponding stability period.

Groups 3 and 4: Groups 3 and 4 include variable hour employees who are determined to work an average of less than 28 hours per week using the Look-Back Measurement Period and during their initial measurement period. Team members in Groups 3 and 4 are eligible only for the employee assistance program (EAP), the MEC medical plan option, Group Accident Insurance, Group Critical Illness Insurance, Group Hospital Indemnity, Pre-paid Legal/ID and the My Wellbeing Program. Team members in Groups 3 and 4 will be eligible for benefits on the first day of the month following 30 days of employment. If an employee in Group 3 or 4 is determined to work an average of 28 or more hours per week, as described in the Look-Back Measurement Policy for Identifying Eligible Employees, he or she shall be reclassified as a Group 2 employee.

Certain members of the Board of Directors of Sprouts Farmers Markets, Inc., within the sole discretion of the Company, may be eligible to participate in specified benefits by either paying the full cost of coverage on an after-tax basis or by having the Company pay the premiums on behalf of the director(s) and impute the value of the premium payments as income to the director(s).

Please see the applicable Benefit Booklets for additional eligibility requirements.

Ineligible Individuals

A person who is not on the regular payroll of the Company or who the Plan Administrator determines is not an employee of the Company (for example, independent contractors or leased employees) is not eligible to participate in the Plan, regardless of whether a court or tax or regulatory authority later determines that the person is an employee.

Dependents Eligible for Medical, Dental and Voluntary Coverage

Your eligible dependents can be enrolled in the Medical, Dental and Voluntary Vision and Supplemental Dependent Life coverage under the Plan only if you are enrolled. Your eligible domestic partner's children can be enrolled in the Medical, Dental and Voluntary Vision coverage if you enroll your domestic partner.

If you are married to, or in a domestic partnership with, another employee of the Company, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

The following dependents are eligible for Medical, Dental, and Voluntary Vision coverage offered under the Plan if you are also enrolled:

- Your spouse (the person to whom you are legally married);
- Your domestic partner (see "Domestic Partner Eligibility" below);
- Your children, your spouse's children, or your domestic partner's children (see below for the definition of children) who are under age 26, regardless of their marital status, and whether or not they live with you or whether you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult child who lives with you and who is primarily dependent on you for support (you must provide appropriate documentation), provided that the child was disabled prior to age 26. Any adult child of your spouse or domestic partner who satisfies this definition will also be eligible.

For purposes of all Plan benefits, children are:

- natural children;
- step children;
- legally adopted children;
- Children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

The following individuals are not eligible for Medical, Dental or Voluntary Vision coverage, regardless of whether they are your tax dependents:

- A spouse, domestic partner or a child living outside the United States;
- Your parent, or a parent of your domestic partner or spouse.

Dependents Eligible for Supplemental Dependent Life

The following dependents are eligible for Supplemental Dependent life insurance coverage offered under the Plan:

- Your spouse;
- Your domestic partner (as defined below);
- Your, your spouse's, or your domestic partner's child under age 26.

Health Care FSA and Limited Purpose Health Care FSA Dependents

For purposes of the Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account, your dependents include:

- Your spouse,
- Your children until the end of the month in which they turn age 26 and are considered a tax dependent
- Your mentally or physically disabled adult children who live with you and who are primarily dependent on you for support, and
- Any other person (including a domestic partner) who meets the Code Section 152 definition of a tax dependent (without regard to the income limit), which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

Dependent Care FSA Dependents

"Eligible dependents" for the Dependent Care Flexible Spending Account include:

- A child under age 13 who is your qualifying child,
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for himself or herself, and who is not the qualifying child of the employee or any other individual.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Domestic Partner Eligibility

A "domestic partner" is an individual who is the same or opposite sex as the eligible employee and who shares a long-term committed domestic partnership with the eligible employee for a minimum 6 consecutive month period. A "domestic partnership" is a relationship between an eligible employee and his or her domestic partner that meets all of the following criteria:

- The partners currently reside together in an exclusive mutual commitment similar to marriage and have done so for at least the past 6 consecutive months and each intend to continue the relationship indefinitely;
- The partners are jointly responsible for basic living expenses;
- The partners are not married to each other or any other individual (statutory or common law) and neither is a member of another domestic partnership;
- Both partners are 18 years or older;

- The partner is not related to you by blood in a way that would prevent you from being married in the state where you both reside;
- Both partners were mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for coverage for the domestic partner;
- Each partner is the other's sole domestic partner and is responsible for the other's common welfare; and
- The partners are financially interdependent, jointly responsible for each other's basic living expenses and able to provide documents for at least 3 of the following situations to demonstrate that interdependence has existed for a minimum of the last 6 consecutive months:
 - Joint mortgage, joint property tax identification or joint tenancy on a residential lease;
 - Joint bank, investment and/or credit account;
 - Joint liabilities (e.g., credit cards, automobile loans);
 - Joint ownership of real property or a common leasehold, interest in real property, such as a residence or business or common ownership of an automobile;
 - A will which designates the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one partner is a beneficiary of the other;
 - Designation of one partner as holding power of attorney for health care or a general durable power of attorney for the other;
 - Written agreement(s) or contracts regarding the domestic partner relationship showing mutual support obligations.

At the time you enroll your domestic partner, you will be required to submit a notarized affidavit attesting that all of the above are true. You must notify the Benefits Department immediately if your domestic partnership ceases to meet the above criteria.

Tax Consequences of Domestic Partner Benefits

Unless your domestic partner and his or her dependent children, if any, are considered your federal tax dependents under the Code, the value of the coverage provided for your domestic partner and his or her dependent children, less any contributions paid by you on an after-tax basis for this coverage, will be imputed to you as income. In general, a domestic partner (or his or her child) who is a member of your household qualifies as your tax dependent for this purpose if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico, or is a child being adopted by a US citizen or national;
- He or she is not a Code Section 152 qualifying child dependent on another taxpayer's filed return or is a Code Section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner and his or her

dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage. You will be required to sign an affidavit stating whether your domestic partner and his or her children, if applicable, are your tax dependents.

Benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify the Company's Benefits Department immediately in writing of this special state income tax status.

Qualified Medical Child Support Orders

The Plan may be required to cover your child pursuant to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO. You may obtain a copy of the Plan's procedures governing QMCSO determinations, free of charge, by contacting the Company's Benefits Department.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets.

Enrollment

New Plan Participants

The Plan Administrator will develop enrollment procedures for each benefit under the Plan. You will receive the information necessary to enroll in the Plan when you become eligible to participate. You and your eligible dependents must affirmatively enroll for coverage by completing an enrollment application online and submitting it within 31 days of the date you become eligible for the following benefits:

- Medical
- Dental
- Voluntary Vision
- Supplemental Life Insurance
- Supplemental Dependent Life Insurance
- Voluntary AD&D
- Voluntary Long-Term Disability

- Voluntary Short-Term Disability (STD)
- Group Accident Insurance
- Group Critical Illness Insurance
- Group Hospital Indemnity
- Pre-paid Legal/ID
- Pre-Tax Premium Payment
- Limited Purpose Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Care Flexible Spending Account
- Health Savings Account (available to employees who enroll in the high deductible health plan option)

If you enroll when first eligible, your coverage will begin on your eligibility date, regardless of the date you enroll.

Eligible employees are automatically enrolled in the following benefits:

- **Basic Life Insurance:** All active employees in Groups 1 and 2.
- **Basic AD&D:** All active employees in Groups 1 and 2.
- **Employee Assistance Plan:** All employees
- **My Wellbeing Program:** All employees (online registration required for access)
- **Short-Term Disability:** All active employees in Groups 1 and 2.

If you and your eligible dependents do not enroll when you are first eligible, you will have to wait until the next Open Enrollment period to enroll, unless you experience a special enrollment event (in the case of Medical benefits) or a qualifying change in status (in the case of certain other benefits). In the case of Supplemental Life Insurance, Supplemental Dependent Life Insurance, Long-Term Disability, and Voluntary Short-Term Disability if you do not enroll when first eligible, you will have to provide evidence of insurability to enroll at a later date. Please refer to the applicable Benefit Booklets for additional details on enrollment.

If you become eligible for coverage later than your initial hire date, your coverage will begin the date you become eligible for coverage according to the terms of the applicable benefit and timely submit any required enrollment application. Your eligible dependents' coverage under the Plan will begin on the same date as yours if you make the necessary elections within the time period required.

If you enroll yourself or a dependent in the Pre-Tax Premium Payment, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, or Health Savings Account Benefits mid-year due to a change in status, coverage will be effective as of the first of the month following the date the Benefits Department receives your timely request for enrollment. However, if you have made a change to your Medical coverage due to marriage, the birth or adoption of a child, your election change will be effective as of the date of the marriage, birth or adoption (or placement for adoption).

Current Plan Participants

Open Enrollment is held every year during the fourth quarter. Open Enrollment is your opportunity to enroll, change, or drop coverage. Changes made during Open Enrollment become effective on January 1 following Open Enrollment. Eligible employees will receive information, including instructions on how to enroll, before Open Enrollment each year.

Contributions

Employee Contributions

You may elect to pay your share of the cost of Medical, Dental and Voluntary Vision coverage on a pre-tax basis (see below under “Section 125 Plan – Pre-Tax Premium Payment” for more information), except to the extent your enrolled eligible dependents do not qualify for pre-tax payments for their coverage. The amount of your contribution required for coverage is determined by the Company and may be changed from time to time.

You may also make contributions to the Health Care, Limited Purpose Health Care, and Dependent Care Flexible Spending Accounts on a pre-tax basis. If you wish to enroll in these benefits, you will be required to agree to have your salary reduced by your elected contribution amount. If you are enrolled in the high deductible health plan medical option, you may make pre-tax contributions to a Health Savings Account.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement.

If you enroll in Voluntary Life, Supplemental Dependent Life, Voluntary AD&D, Dependent AD&D, Voluntary Short-Term Disability, and Voluntary Long-Term Disability coverage, you pay the cost for coverage on an after-tax basis.

Contributions are deducted from your paycheck in accordance with the level of coverage you elect.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to the Benefits Department at Sprouts Farmers Markets Holdings, LLC, 5455 E. High Street, Suite 111, Phoenix, AZ 85054 or have double deductions until the balance is paid in full upon return.

Contributions for Non-Tax Dependents

If you elect Medical, Dental, and Vision coverage for your eligible domestic partner and his or her eligible children, you will be asked if they are your federal tax dependents at the time of enrollment. If they are not your federal tax dependents, you will be required to pay contributions for domestic partner coverage on an after-tax basis, and the amount the Company contributes toward your domestic partner’s coverage will be treated as imputed income to you. The amount of imputed income will be added to your wages each payroll period and will be subject to income tax withholding. In addition, the Company will report the annual total of this imputed income on your W-2 Form at the end of each year. Before enrolling your domestic partner and his or her eligible children, you should talk to your tax advisor about the tax implications for you.

Section 125 Plan – Pre-Tax Premium Payment

This Plan includes a premium payment benefit under Code Section 125 in order for you to be able to pay your contributions for the Medical, Dental and Voluntary Vision coverage on a pre-tax basis.

Making Changes to Your Coverage During the Year

HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent child(ren). However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

The Plan is not required to extend the HIPAA special enrollment rights to a newly acquired domestic partner; however, the Plan will treat a new domestic partner the same as a new spouse for purposes of the HIPAA special enrollment rights described above. Any children of a new domestic partner will be also be allowed to enroll as if they were the children of a new spouse.

If you request special enrollment within the 60-day timeframe, in the case of a new dependent due to birth, adoption, or placement for adoption, coverage will be effective on the date of birth, adoption or placement for adoption. In the case of a new spouse or dependent due to marriage, coverage will become effective on the event date.

If you or an eligible dependent loses eligibility for Medicaid or state Children's Health Insurance Program (CHIP) coverage, or if you or your eligible dependent become eligible for a state's premium assistance program, you and/or your dependent will be allowed to enroll in the Medical benefits under the Plan. You must request enrollment in the Plan within 60 days from the date of the Medicaid/CHIP event. If you request this change, coverage will be effective the first of the month following your loss of coverage. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact the Company's Benefits Department.

Changes in Status

In general, the elections you make to pay your Medical, Dental, and Voluntary Vision premiums on a pre-tax basis, or under the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account are irrevocable for the entire Plan Year. However, you may change your elections during a Plan Year to the extent permitted under Code Section 125. Accordingly, if you experience one of the events described below, and want to make a change to your elections due to such event, you must notify the Company within 60 days of the event (or such other time period provided below). If you do not notify the Company within the required period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

You may be able to change your Pre-tax Premium Payment for Medical, Dental, Voluntary Vision, or your elections under the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account elections during the Plan Year if you experience a qualifying change-in status event and your changed election is consistent with the change in status, as described below. Please note that in order to change your benefit elections due to a qualifying change-in status event, you may be required to show proof verifying that at least one of these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Change in domestic partnership status:** Commencement or dissolution of a domestic partnership if your domestic partner is your tax dependent;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status (effective January 1, 2020):** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or ending employment;
 - A strike or lockout;
 - Starting or returning from an unpaid leave of absence;
 - Change in number of hours worked; and
 - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in you or your eligible dependents living outside your Medical, Dental or Voluntary Vision plan's network service area;*
- **HIPAA Special Enrollment Events:** Events such as the loss of other coverage that qualify as special enrollment events under HIPAA;
- **FMLA leave:** Beginning or returning from an FMLA leave; and

Permitted changes in status will include qualifying change in status events affecting children under age 26, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

*Note: An employee that is enrolled in the HMO option and who relocates outside the State of California will be automatically enrolled in the HDHP option if an enrollment change form is not received by the Plan Administrator within 31 days of the change in residence.

Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be on account of and correspond with the event. To satisfy this consistency rule, both the event and the corresponding change in coverage must meet all the following requirements:

- The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for other coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.

- The election change must correspond with the event. For example, if your dependent child loses eligibility for Medical coverage, you may cancel Medical coverage only for that dependent child. You may not cancel coverage for yourself or other covered dependents.

Other Events that Allow You to Change Elections

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group Medical programs, you may make a corresponding change to your elections for Medical, Dental, and Voluntary Vision coverages and the Health Care Flexible Spending Account.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator will automatically change your election under the Plan to provide coverage for that child.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

Cost or Coverage Change Events

In some instances, you can make changes to your elections mid-year if the type of coverage or cost of coverage changes. These rules do not apply to the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account. If the change occurs to another employer's plan, you may be required to show proof that these events have occurred.

Cost Changes. If the Company determines there is a significant increase or decrease in the cost of Medical, Vision, or Dental coverage, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election.

Any change in the cost of your coverage that the Company determines is not significant will result in an automatic increase or decrease, as applicable, of your share of the total cost for coverage.

Coverage Changes. The following are additional situations in which you may change your coverage elections mid-year:

- **Restriction or Loss of Coverage** – If your coverage is significantly restricted or ceases entirely, you may revoke your election for that coverage and then elect coverage under another option that provides similar coverage. Coverage is considered “significantly restricted” if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election without electing another option.
- **Addition to or Improvement in Coverage** - If the Plan adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.
- **Changes in Coverage under Another Employer Plan** - If your spouse or dependent child(ren) is

employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's annual enrollment period or due to a mid-year election change permitted under the Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer's annual enrollment period, you may request to end your coverage under the Plan.

- **Loss of Other Group Health Plan Coverage** - If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), Medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

Dependent Care Flexible Spending Account Cost or Coverage Changes. In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account election if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you),
- You choose a different dependent care provider who charges a different amount, or
- You make a change to you or your spouse's regular work schedule that increases or decreases your need for dependent care.

Exchange Enrollment

If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Medical coverage, provided that you certify that you and any dependents whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical coverage.

Change in HSA Elections

If you have enrolled in the Plan during Open Enrollment and have elected the high deductible health plan option and the HSA, then you may increase, decrease, or revoke your HSA election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. Such an election change will be effective with the first day of the next calendar month following the date your election change request is submitted.

No other benefit package option election changes can be made as a result of a change in your HSA election unless permitted as a result of events otherwise described in this section.

Coverage During Leave of Absence

During a leave of absence you may continue your coverage under the Plan for up to six months (or longer where required by law) by paying all required premiums, except for the MEC and Voluntary plans, in which you're required to pay the vendor directly. If you are unable to pay your premium contribution during leave, the Company may pay your share of the premiums for you. If the Company elects to do so, you will be responsible for repaying the amount with double deductions upon your return to work.

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence under the Family and Medical Leave Act of 1993 (FMLA) and Military Leave of Absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For more information about any type of leave of absence, contact the Benefits Department at Sprouts Farmers Markets Holdings, LLC, 5455 E. High Street, Suite 111, Phoenix, AZ 85054, 480-814.8016.

FMLA Leave

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Voluntary Vision, Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave. If you are unable to pay your contribution during leave, the Company may pay your share of the premiums for you. You will be responsible for repaying the amount with double deductions upon your return to work. You also have the option to suspend your health coverage during part or all the unpaid leave. For additional information on continuing your benefits during an FMLA leave, please contact the Benefits Department at Sprouts Farmers Markets Holdings, LLC, 5455 E. High Street, Suite 111, Phoenix, AZ 85054, 480-814-8016.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, your coverage will be reinstated when you return to work at the end of your FMLA leave and make your required contributions.

If you elect to suspend your Health Care FSA or Limited Purpose Health Care FSA coverage during your leave, that coverage can be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the FSA at the same level in effect before your leave, or you may elect to increase your contributions to “make up” for contributions you missed during your leave. If you choose to resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

Your contributions to the Dependent Care FSA will continue during a paid leave, but will be suspended if the leave is unpaid.

Your Employee Assistance Program, Basic Life, AD&D, and access to the Wellbeing Program will continue during an FMLA leave. Your MEC (for Groups 3 and 4 only), Supplemental Life, Supplemental Dependent Life, Voluntary AD&D, Voluntary Long-Term Disability, Group Critical Illness, and Voluntary Short-Term Disability coverages will continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. If you fail to make the required contributions during your leave, your coverage will be terminated until you return from your FMLA leave, at which time coverage will be reinstated.

If you do not return to work at the end of your FMLA leave you may be entitled to elect to continue your coverage through COBRA (see page 21).

Military Leave

If you take a military leave under USERRA, you are entitled to extend your Medical, Dental, Vision, Employee Assistance Plan, Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account coverage for up to 24 months.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave. All coverages will continue during your military leave up to 30 days, and then employees can arrange for extended coverage up to 24 months, but must pay the entire premium.

If you take a military leave, but your coverage under the Plan is terminated - for instance, because you do not elect the extended coverage - when you return to work with the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see page 21). However, your USERRA benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be considered an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your spouse or dependent children covered by the Plan) different rights or protections, the law that provides the greater benefit will apply.

When Coverage Ends

Your coverage under this Plan will terminate at midnight on the earliest date any of the following occur:

- The date the Plan or benefit option is terminated;
The last day of the calendar month in which you cease to be an eligible employee. This includes your death, termination of employment, or reduction of hours of employment (including a leave of absence, unless you elect to continue coverage through COBRA, or you are entitled to continue coverage under the FMLA or USERRA);
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- If you commit fraud or make a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then your coverage may be terminated as of a date to be determined at the Company's discretion, consistent with applicable law.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain Medical procedures) are described in the Benefit Booklets.

Coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates, unless they are covered separately as an eligible employee under the Plan. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, coverage will terminate:

- For your dependent child, for Medical, Dental, and Voluntary Vision coverage, the end of month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The date (or, the last day of the month for Medical, Dental, and Voluntary Vision coverage) in which your legally married spouse, domestic partner or child is no longer considered an eligible dependent under the terms of this Plan; and
- The end of the period for which you paid your required contribution for dependent coverage if the contribution for the next period is not paid when due.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

Pre-Tax Premium Payment, Health Care FSA, Limited Purpose Health Care FSA, Dependent Care FSA or HSA After Termination of Employment or Loss of Eligibility

If the employee terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within the same month, he or she will be reinstated with the same elections that were in place before termination. If a former employee is rehired following termination of employment and is otherwise eligible to participate in the Plan, then he or she may make new elections as a new hire. Notwithstanding the above, an election to participate in the Pre-Tax Premium Payment benefit will be reinstated only to the extent that coverage under the Medical, Dental and Vision benefits are reinstated. Likewise, an HSA election will only be reinstated if the employee is an HSA-Eligible individual. If an employee ceases to be eligible to participate in this Plan for any reason (other than during FMLA or USERRA leave, or termination of employment), including (but not limited to) a reduction of hours, and then becomes an eligible employee again, the employee must complete any applicable waiting period before again becoming eligible to participate in the Plan.

Rescission of Coverage

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if you act fraudulently or intentionally make a material misrepresentation of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also your responsibility to update previously provided information and statements. Failure to do so may result in coverage being canceled, and such cancellation may be retroactive.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A covered individual whose coverage is being rescinded will be provided thirty (30) days' prior notice of the rescission. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage is provided under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations. When you and your dependents become entitled to COBRA, you are known as a “qualified beneficiary.”

Federal law does not recognize your domestic partner or his or her children (who are not also your children) as COBRA qualified beneficiaries. However, domestic partners and their children will be offered COBRA-like continuation rights under this Plan. For a description of the continuation coverage that will be offered to domestic partners and their children, refer to the provisions in this section relating to spouses and dependent children.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it.

COBRA applies to Medical, Dental, Voluntary Vision, EAP, Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan.

For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator:

Benefits Department
Sprouts Farmers Markets Holdings, LLC
5455 E. High Street, Suite 111
Phoenix, AZ 85054
Phone number: 480-385-2300

You may have other options available to you when you lose coverage

For example, you may be eligible to buy an individual plan through the Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event.” After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will

have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

Who Can Elect COBRA Coverage

Employees

If you are an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualified events:

- A reduction in your hours of employment with the Company, or
- The termination of your employment with the Company (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of the employee;
- The termination of the employee's employment (for reasons other than gross misconduct);
- A reduction in the employee's hours of employment;
- The employee's entitlement to Medicare; or
- Divorce or legal separation from the employee. Also, if the employee reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events happen:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct)
- A reduction in the employee's hours of employment;
- The employee's divorce, legal separation, or dissolution of a domestic partnership;
- The employee's entitlement to Medicare; or
- You cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- You were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and

- You lose group health coverage under the Plan because you do not return to work at the end of the leave.

Your COBRA qualifying event occurs on the earliest of the following:

- When you definitively inform the Company that you are not returning at the end of your leave; or
- The last day of your FMLA leave, if you do not return to work.

Newly Eligible Child

If you, the former employee, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to your COBRA coverage by providing the Plan Administrator (see Contact Information section below) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 60 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the Plan Administrator within the 60 days, you will not be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) other than those born to, adopted by, or placed for adoption with the employee will not be COBRA qualified beneficiaries, but may be added to the employee's coverage at Open Enrollment.

QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified Medical child support order (QMCSO) is entitled to the same rights to elect COBRA as any other dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is a termination of employment, reduction of hours of employment or death of the employee, the Plan will notify all qualified beneficiaries of their right to elect COBRA coverage.

For a qualifying event which is a divorce, legal separation, or dissolution of a domestic partnership, the employee's entitlement to Medicare or a dependent child's losing eligibility for coverage, you must notify the Plan Administrator of the qualifying event in writing within 60 days of the date of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice. Failure to provide timely notice will result in a loss of COBRA rights.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must to provide documentation supporting the occurrence of the qualifying event, if

requested by the Plan Administrator. You must mail or hand-deliver this notice to the Plan Administrator at the address listed under “How to Elect COBRA” below.

If the above procedures are not followed or if the notice is not provided to the Plan Administrator within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are paid for expenses incurred after the date your coverage ends due to the qualifying event, you will be required to reimburse the Plan for such claims.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form and return it to:

WageWorks
P.O. Box 14053
Lexington, KY 40512

An election notice will be provided to qualified beneficiaries within 44 days of the qualifying event that is the termination of employment, reduction of employment hours or death of the employee, or within 14 days of the date you notify the Plan Administrator of your divorce, legal separation or dissolution of a domestic partnership, a child’s loss of dependent eligibility or the employee’s entitlement to Medicare.

You must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage under COBRA

Initially, your COBRA coverage will be the same coverage as immediately preceding your qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees and dependents that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, special enrollment rights under HIPAA will apply to those who have elected COBRA.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she first becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the COBRA election form, you must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

COBRA and Health Care FSAs and Limited Purpose Health Care FSAs

COBRA coverage under the Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account will be offered only through the end of the Plan Year during which the qualifying event occurred, and only if the employee has a positive account balance at the time of the qualifying event, taking into account all claims submitted before the qualifying event. The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account COBRA coverage.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change during your period of COBRA coverage. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

COBRA premiums may be paid by cash, check, money order, ACH, or online payment with a credit card. Your first payment and all monthly payments for COBRA coverage must be sent to:

WageWorks
P.O. Box 14053
Lexington, KY 40512

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds.

Your first payment must cover the cost of COBRA coverage from the date your coverage under the Plan would have otherwise terminated, through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact WageWorks to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it and make the required payment. Claims under the Plan will not be processed and paid until you have elected COBRA and paid all premiums due.

Duration of COBRA Coverage

If you lose Plan coverage because of termination of employment or reduction in hours, you may elect to continue your coverage under COBRA for a maximum of 18 months. For all other qualifying events, the maximum duration of your COBRA coverage is 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. COBRA coverage for the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account cannot be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary becomes disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have commenced at sometime within the first 60 days of the start of the 18-month COBRA continuation period, and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the Plan Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must provide this notice before the end of the first 18 months of continuation coverage in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;

- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the Plan Administrator. If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the Plan Administrator of this determination within 30 days of the date it is made, and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours.

Second qualifying events include an employee's death, divorce, becoming entitled to Medicare or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18 months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the Plan Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. You must mail this notice to the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- The Company no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- After the date COBRA is elected, the qualified beneficiary first becomes covered under another group health plan (whether or not as an employee);
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both); or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.
- COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Plan, the insurance carriers and/or HMOs may require you to repay all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the Plan Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See “29-Month Qualifying Event (Due to Disability)” section above.

Contact Information

If you have any questions about COBRA coverage, please contact:

WageWorks
P.O. Box 14053
Lexington, KY 40512
Phone number: 855-774-7441

You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa. For more information about coverage through the Marketplace, visit www.healthcare.gov.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less

than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Keep the Plan Informed of Address Changes

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

Special COBRA Rights for California Employees

If you are enrolled in a Medical HMO or insured Medical coverage in California at the time of your initial qualifying event, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost).

This special California continuation benefit is provided by the HMOs and insurance companies and is not part of this Plan. Contact your HMO or insurance carrier at the address in the applicable Benefit Booklet to find out whether you are eligible for this continuation benefit and how to obtain it.

Converting Coverage After Termination

If you are eligible to convert your Plan coverage to an individual policy, you will be sent a conversion notice within the last 180 days of COBRA coverage. Contact the applicable HMO or insurance company at the address listed in the applicable Benefit Booklet for information on converting to an individual policy.

Covered and Non-Covered Services

Refer to the Benefit Booklets for a specific listing of covered and non-covered services and a description of all cost-sharing provisions under your benefits.

Special Rights for Mothers and Newborn Children

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Newborns' and Mothers' Health Protection Act. For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Women's Health and Cancer Rights Act of 1998. The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy.

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- 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 at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other Medical and surgical benefits covered under the Plan.

Designation of Primary Care Providers

You have the right to designate any primary care provider who participates in the Plan's or the applicable insurance carrier's or HMO's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider.

Access to OB/GYN

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Mental Health Parity and Addiction Equity Act of 2008

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance use disorder benefits relating to financial cost-sharing restrictions and treatment-duration limitations. For further details, please contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with GINA.

Health Care Flexible Spending Account Benefits

The Health Care Flexible Spending Account may be of interest to you if you have health care expenses that are not fully reimbursed by, or not covered by other health plan coverage. If you are enrolled in the HSA-compatible high deductible health plan option under this Plan, you may not enroll in the Health Care Flexible Spending Account.

The Health Care Flexible Spending Account allows you to elect to set aside pre-tax dollars from your paycheck to pay for certain health care expenses. By participating, you will receive in health care expense reimbursement a portion of what would otherwise be your regular pay. Your election to participate in this benefit reduces the amount of taxable income you receive and, therefore, reduces the amount of taxes you pay.

Covered Dependents

You may submit health care expenses incurred by you, your spouse, and your dependents as listed in the “Health Care FSA and Limited Purpose Health Care FSA Dependents” section on page 9.

Contribution Limits

You may contribute any whole dollar amount of not more than \$2,650 (or such other limit as adjusted by the Internal Revenue Service) per Plan Year to your Health Care Flexible Spending Account. Contributions will be withheld from your pay each pay period on a proportional basis throughout the Plan Year. The full amount of your election for the Plan Year, minus any prior reimbursements, will be available for reimbursement as of the first day of the Plan Year.

Eligible Expenses

To be eligible for reimbursement, health care expenses must have been incurred during the Plan Year while you were covered under the Plan, and must be for medical care as defined in Code Section 213. An expense is considered incurred when the care or service is provided--not when the provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care that you are obligated to pay and that are not reimbursed by any other source.

Medical care expenses that may be reimbursed by your Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person’s general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Reimbursable expenses may include amounts that are not otherwise paid by this Plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Over-the-counter medications (except insulin) are not eligible for reimbursement without a prescription. You will need a doctor’s prescription indicating that the medications are medically necessary in order to be reimbursed from the Health Care FSA. Insulin may be reimbursed without a prescription. You may submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over the counter if they are used for the diagnosis, treatment or prevention of disease. Below is a partial list of expenses eligible for reimbursement under the Health Care Flexible Spending Account:

- **Medical Expenses**

- Deductibles
- Copayments
- Charges for routine check-ups, physical examinations, and tests connected with routine exams
- Charges over the “reasonable and customary” limits
- Expenses not covered by a group health plan due to an exclusion
- Drugs requiring a doctor’s written prescription that are not reimbursed by insurance or group health plan

- Over-the-counter items as permitted under applicable law or regulation
- Over-the-counter drugs, if obtained with a prescription, and only as permitted under applicable law or regulation
- Insulin (which may be reimbursed without a prescription)
- Smoking cessation programs and related medicines
- Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
- Other selected expenses not covered by a group health plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches)
- **Dental Expenses**
 - Deductibles
 - Copayments
 - Expenses that exceed the maximum annual amount allowed by your dental plan
 - Charges over the “reasonable and customary” limits
 - Orthodontia treatments that are not strictly cosmetic
- **Vision and Hearing Expenses**
 - Vision examinations and treatment not otherwise covered by a vision benefit plan
 - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
 - Cost of hearing exams, aids and batteries
- **Transportation**
 - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

Ineligible Expenses

Below is a partial list of expenses *not* eligible for reimbursement under the Health Care Flexible Spending Account:

- Premiums
 - Premiums paid by an employee, a spouse or other dependents for coverage
 - Premiums paid for Medicare
 - Premiums paid for long-term care insurance
 - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Over-the-counter drugs or items without a prescription unless specifically permitted under applicable law or regulation

- Cosmetic procedures
 - Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- Expenses related to general health
 - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care.
 - Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.
- Long-term care expenses

The Internal Revenue Service does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care Flexible Spending Account.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Code's rules for tax deductibility. For more information, contact the Claims Administrator.

Use It or Lose It

You must use the full amount of money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year or forfeit what remains at the end of the Plan Year. Notwithstanding the foregoing, if you have unused funds in your Health Care Flexible Spending Account, you may carry over up to \$500 for use after March 15 of the next Plan Year. **Any funds remaining in your Account after that date will be forfeited.** It is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. Set aside only as much as you expect to use during the Plan Year or you will lose it.

Your request for reimbursement for expenses incurred during a Plan Year must be filed by the March 15 following the end of the Plan Year.

You may not use money in your Health Care Flexible Spending Account to pay dependent day care expenses and you may not use amounts in your Dependent Care Flexible Spending Account to pay for health care expenses.

Filing a Claim

Claim forms are available from the Claims Administrator listed in Appendix B. When you incur eligible health care expenses, you may submit a claim form along with adequate documentation of the expense (e.g., an invoice, detailed receipt, explanation of benefits from an insurance carrier or HMO, or other documentation requested by the Claims Administrator). Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money you have contributed to-date, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account for the Plan Year. Thereafter, you must still continue making contributions on a regular basis for the remainder of the Plan Year.

All claims for a Plan Year must be submitted to the Claims Administrator by March 15. Any claims for reimbursement submitted after that date will not be considered for reimbursement by the Claims Administrator.

Limited Purpose Health Care Flexible Spending Account Benefits

The Limited Purpose Health Care Flexible Spending Account may be of interest to you if you are enrolled in the HSA-compatible high deductible health plan and you plan to contribute to a Health Savings Account (HSA).

The Limited Purpose Health Care Flexible Spending Account allows you to elect to set aside pre-tax dollars from your paycheck to pay for limited types of health care expenses. By participating, you will receive in health care expense reimbursement a portion of what would otherwise be your regular pay. Your election to participate in this benefit reduces the amount of taxable income you receive and, therefore, reduces the amount of taxes you pay.

The Limited Purpose Health Care Flexible Spending Account reimburses only Medical expenses that are considered to be for preventive, dental, and vision expenses as allowed under Code Section 223; however, once you have satisfied the deductible under the high deductible health plan, all eligible Medical expenses may be reimbursed.

Covered Dependents

You may submit expenses incurred by you, your spouse, and your tax dependents as defined in the “Health Care FSA and Limited Purpose Health Care FSA Dependents” section on page 9.

Contribution Limits

You may contribute any whole dollar amount of not more than \$2,650 (or such other limit as adjusted by the Internal Revenue Service) per Plan Year of your own money to your Limited Purpose Health Care Flexible Spending Account. Contributions will be withheld from your pay each pay period on a proportional basis throughout the Plan Year. The full amount of your election for the Plan Year, minus any prior reimbursements, will be available for reimbursement as of the first day of the Plan Year.

Eligible Expenses

To be eligible for reimbursement, expenses must have been incurred during the Plan Year while you were covered under the Plan. An expense is considered incurred when the care or service is provided--not when the provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for preventive, dental or vision care, which you are obligated to pay and that are not reimbursed from any other source.

Below is a partial list of dental and vision expenses eligible for reimbursement under the Limited Purpose Health Care Flexible Spending Account:

- Dental Expenses
 - Deductibles and Copayments
 - Expenses that exceed the maximum annual amount allowed by your dental plan charges over the “reasonable and customary” limits

- Orthodontia treatments that are not strictly cosmetic
- Vision Expenses
 - Vision examinations and treatment not covered by insurance plan
 - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner

Ineligible Expenses

Below is a partial list of expenses not eligible for reimbursement under the Limited Purpose Health Care Flexible Spending Account:

- Medical Expenses
 - Expenses, other than preventive care, incurred before your medical coverage deductible is met
- Premiums
 - Premiums paid by the employee, a spouse or other dependents for coverage under any group health plan
 - Premiums paid for Medicare
 - Premiums paid for long-term-care insurance
 - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Prescription or Non-prescription Drugs
 - Expenses incurred before your medical coverage deductible is met
 - Over-the-counter drugs or items without a prescription unless specifically permitted under applicable law or regulation
- Cosmetic procedures that are strictly cosmetic, such as teeth bleaching.
- Expenses related to general health
- Long-term care expenses

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Code's rules for tax deductibility.

The Internal Revenue Service does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Limited Purpose Health Care Flexible Spending Account.

Use It or Lose It

You must use the full amount of money in your Limited Purpose Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year or forfeit what remains at the end of the Plan Year. Notwithstanding the foregoing, if you have unused funds in your Limited Purpose Health Care Flexible Spending Account, you may carry over up to \$500 for use after March 15 of the next Plan Year. Any funds remaining in your account after that date will be forfeited. It is extremely important that you carefully plan your contributions to your Limited Purpose Health Care Flexible Spending Account. Set aside only as much as you expect to use during the Plan Year or you will lose it.

Your request for reimbursement for expenses incurred during a Plan Year must be filed no later than the March 15 following the end of the following Plan Year.

You may not use money in your Limited Purpose Health Care Flexible Spending Account to pay dependent day care expenses and you may not use amounts in your Dependent Care Flexible Spending Account to pay for health care expenses. You may not switch money between the two accounts.

Filing a Claim

Claim forms are available from the Claims Administrator listed in Appendix B. When you incur eligible health care expenses, you must submit a claim form along with adequate documentation of the expense (e.g., an invoice, detailed receipt, explanation of benefits from an insurance carrier or HMO, or other documentation requested by the Claims Administrator.) Claims can be submitted on a daily basis and reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of your contributions to-date, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account for the Plan Year. Thereafter, you must still continue making contributions on a regular basis for the remainder of the Plan Year.

All claims for a Plan Year must be submitted to the Claims Administrator by March 15. Any claims for reimbursement submitted after that date will not be considered for reimbursement by the Claims Administrator.

Health Savings Account Benefits

If you enroll in the high-deductible health plan Medical option and are otherwise eligible to contribute to a health savings account (HSA), you may elect to make contributions on a pre-tax salary reduction basis to an HSA established and maintained outside the Plan by a trustee/custodian to which the Company can forward your contributions to be deposited. Your election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

This HSA benefit cannot be elected with Health Care Flexible Spending Account unless you elect the Limited Purpose Health Care Flexible Spending Account option.

Contributions for Cost of Coverage for HSA; Maximum Limits

Your annual contribution to your HSA cannot exceed the statutory maximum amount for HSA contributions applicable to your high-deductible health plan coverage option (i.e., single or family) for the calendar year in which the contribution is made (\$3,500 for single and \$7,000 for family are the statutory maximum amounts for 2019).

An additional catch-up contribution of \$1,000 may be made for eligible employees who are age 55 or older.

In addition, the maximum annual contribution shall be:

- (a) reduced by any matching (or other) Company contribution made on your behalf (other than pre-tax salary reductions) made under the Plan); and
- (b) prorated for the number of months in which you are an HSA-eligible individual.

Recording Contributions for HSA

The HSA is not a Company-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Company, will establish and maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions you make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Company has no authority or control over the funds deposited in an HSA.

Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible Medical expenses, claims procedures, etc.) will be provided by and are set forth by the IRS and the HSA custodian, not this Plan. The terms and conditions of each employee's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing employee and are not a part of this Plan.

The HSA is not a company-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of “qualified eligible Medical expenses” as set forth in Code §223(d)(2). The Company has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Company.

Dependent Care Flexible Spending Account Benefits

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

The Dependent Care Flexible Spending Account allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

Qualifying Individuals

Your dependents who qualify for the dependent care reimbursement account include:

- A person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
- Your spouse (not a domestic partner) who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year;
or

- A person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to certain provisions of the Code definition).

Contribution Limits

The maximum amount you may contribute to your Dependent Care Flexible Spending Account is \$5,000. Reimbursement from the account is treated as tax-free up to the \$5,000 limit. However, tax-free treatment is limited to \$2,500 each if you and your spouse file separate income tax returns. In addition, tax-free treatment for reimbursement cannot exceed the lesser of your or your spouse's annual earnings.

For example: During 2019, Mary will earn \$41,500 from her job. Her husband will earn \$3,600 from his job. Mary's tax-free treatment for reimbursement from her Dependent Care Flexible Spending Account will be limited to \$3,600. She can choose to contribute no more than \$300 a month ($\$300 \times 12 = \$3,600$) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or \$250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or \$500 a month.

Only the amount you have contributed to date, less any prior reimbursements, will be available for reimbursement at any given time during the Plan Year.

Eligible Expenses

Eligible expenses for reimbursement under the Plan include expenses incurred for the care of your qualified dependents:

- In your home,
- In another person's home,
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there, or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you - or if you're married, you and your spouse -to work or look for work. If your spouse is not working or looking for work, he or she must be disabled and unable to care for him/herself or be a full-time student. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided-not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child or dependent, not for education, meals, etc., unless incidental to the cost of care.

Ineligible Expenses

You cannot use the money in your Dependent Care Flexible Spending Account to pay for:

- General “baby-sitting” other than during work hours
- Care or services provided by:
 - Your children under age 19 (whether or not they are your tax dependents)
 - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off work for any reason; however, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible.
- Expenses for which you claim IRS child care credit when you file your tax return

Ask the Claims Administrator if you need further information about which expenses are—and are not—likely to be reimbursable.

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Flexible Spending Account.

Use It or Lose It

It is important that you plan carefully when deciding how much to contribute to the Dependent Care Flexible Spending Account.

IRS regulations stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year or you will forfeit what remains. You must incur eligible expenses by the end of the Plan Year in order for them to be eligible for reimbursement. Your request for reimbursement must be filed within 90 days after the Plan Year in which funds are allocated to your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year. Any funds remaining in your account after that date will be forfeited.

It is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

You may not use money in your Dependent Care Flexible Spending Account to pay health care expenses and you may not use amounts in your Health Flexible Spending Account to pay for dependent care expenses. You may not switch money between the two accounts.

Filing a Claim

Claim forms are available from the Claims Administrator listed in Appendix C. When you incur eligible dependent care expenses, you may submit a claim form along with the invoice, receipt, or such other documentation of the expense as requested by the Claims Administrator. Claims can be submitted on a daily basis and must be at least \$25.00 or more before reimbursement will be made. Claims will only be reimbursed to the extent that you have contributed sufficient funds to your Dependent Care Flexible Spending Account. If your claim is greater than the amount of money in your account, you will be reimbursed for the amount of your claim up to the amount remaining in your account. If further contributions are made in the Plan Year or the grace period, the remaining portion of your eligible expense will be reimbursed after such contributions are made. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a Plan Year must be submitted to the Claims Administrator by the March 15 after the end of the Plan Year. Any claims for reimbursement submitted after that date will not be considered for reimbursement by the Claims Administrator.

Special Rules Affecting Dependent Care Accounts

Several special rules apply to Dependent Care Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The federal income tax law also has a tax credit that an individual can claim in relation to dependent care expenses. However, any reimbursements you receive from your Dependent Care Flexible Spending Account must be deducted - dollar for dollar – from the maximum dollar amount of expenses that you can use to claim the federal income tax credit. *Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care Flexible Spending Account. Please consult your tax advisor or carefully review your situation before making a choice.*

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

Use of Forfeitures

All forfeitures under this Plan from the Health Care Flexible Spending Accounts, Limited Purpose Health Care Flexible Spending Accounts, and Dependent Care Flexible Spending Accounts shall be used as follows: first, to offset any losses experienced by the Company during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all participants in excess of the contributions paid by such participants through salary reductions, and second, to reduce the cost of administering the Health FSA benefits during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator). In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical care expense was incurred shall be forfeited and applied as described above.

Use of Debit Cards

If the Company allows the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, and/or Dependent Care Flexible Spending Account to be accessed by an electronic

payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs.

In addition, the following provisions shall apply:

- *Initial and Periodic Certification.* Before receiving an electronic payment card, you must certify that you will only use the card to pay for Medical care or dependent care expenses (as applicable), will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. You must also agree to abide by any other the terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from your compensation and offsetting against other claims. You must reaffirm these agreements during each subsequent Open Enrollment period in order for the card to remain activated. In addition, these agreements are reaffirmed each time you use the card. Failure to abide by these agreements may result in deactivation of the card.
- *Deactivation of Card.* Your card will be deactivated when participation in the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, and/or Dependent Care Flexible Spending Account ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). If your card has been deactivated, you must request reimbursement for Medical care or dependent care expenses (as applicable) through other methods (e.g., by submitting paper claims).
- *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of your available reimbursement. Each time the card is swiped, you certify to the Plan that the expense for which payment under the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, or Dependent Care Flexible Spending Account, as applicable, is being made is a reimbursable expense under the Plan, that it has not already been reimbursed from another source, and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.
- *Documentation.* For each expense that is paid with the card, you must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If you are asked to provide the documentation to the Plan, you must do so within the period specified in the request. If you are unable to provide adequate or timely substantiation upon request from the Plan, you must repay the Plan for the unsubstantiated expense. In addition, your card may be deactivated.
- *Correction of Improper Payments.* You must repay the Plan for any improper payments that are made with your card. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Company will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Company forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

Election Modifications Required by the Plan Administrator

The Plan Administrator may, at any time, require any participant or class of participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Plan Year if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any employee or class of employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Company's qualified plans. In the event that contributions need to be reduced for a class of participants, the Plan Administrator will reduce the salary reduction amounts for each affected participant, beginning with the participant in the class who had elected the highest salary reduction amount and continuing with the participant in the class who had elected the next-highest salary reduction amount, and so forth, until the defect is corrected.

Claims and Appeal Process

Filing a Claim

Sprouts will decide all claims related to the Plan which are based on an Employee's eligibility to participate in the Plan. Claims related to eligibility to participate in a Plan must be filed with the Sprouts Benefits Department.

All other claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. The Claims Administrator's customer service representatives are available to answer any questions or concerns regarding benefits under the Plan. Telephone representatives are not authorized to change the terms of the Plan.

In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators, listed in the table below, and in Appendix C. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

In general, when you need to file a claim, use the addresses listed in the Benefit Booklets, on the applicable claims form, or as listed below and in Appendix C. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claims Administrators - Fully Insured Benefits

The following Plan benefits are provided through contracts with the insurance companies listed below: The Medical (HMO), Minimum Essential Coverage (MEC) Medical, Voluntary Vision, Basic Life Insurance, Supplemental Life Insurance, Supplemental Dependent Life Insurance, Basic AD&D, Voluntary AD&D, Voluntary STD, STD, LTD, EAP, Group Accident Insurance, Group Critical illness Insurance, Group Hospital Indemnity, My Wellbeing Program and Pre-paid Legal/ID. The insurance companies administer claims/or those benefits, and are solely responsible for providing benefits,

establishing the claims procedures to be followed, and deciding all claims and appeals with respect to those Plan benefits.

Medical (HMO)	Kaiser Permanente
Minimum Essential Coverage (MEC) Medical	Reliance
Voluntary Vision	Avesis
Basic, Supplemental Life, Supplemental Dependent Life; Basic and Voluntary Accidental Death and Dismemberment (AD&D)	Unum
Voluntary Short-Term Disability, Short-Term Disability (STD) Insurance Voluntary Long-Term Disability (LTD) Insurance	Unum
Employee Assistance Plan (EAP)	Magellan
Group Accident Insurance, Group Critical Illness Insurance, Group Hospital Indemnity	Unum
My Wellbeing Program	Limeade
Pre-paid Legal /ID	LegalShield

Claims Administrators - Self-Insured Benefits

The Medical Plan, Dental Plan, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account and Dependent Care Flexible Spending Account are self-insured. United HealthCare has the responsibility for determining whether you are entitled to benefits and authorizing payment under the Medical Plan, Metropolitan Life Insurance Company has the responsibility for determining whether you are entitled to benefits and authorizing payment under the Dental Plan and WageWorks has the responsibility for determining whether you are entitled to benefits and authorizing payment under the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, or Dependent Care Flexible Spending Account. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Medical Plan	UnitedHealthcare
Dental Plan	Metropolitan Life Insurance Company – MetLife Preferred and Basic Plans
Health Care Flexible Spending Account/Limited Purpose FSA	WageWorks
Dependent Care Flexible Spending Account	WageWorks

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information.

Claims - HSA

Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA

trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit (i.e., medical, dental, vision) claims:

- **Urgent Care Claims.** "Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.
- **Pre-Service Claims.** "Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).
- **Post-Service Claims.** "Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.
- **Concurrent Care Claims.** "Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" - a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not Medically necessary or appropriate;
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for Medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there

is an adverse effect on any particular benefit at that time. Rescissions are only permitted in the event of fraud or intentional misrepresentation of material fact.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The contact information for each Claims Administrator is included in the applicable Benefit Booklet for such benefit.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on Medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

The notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

For Medical claims the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "Medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account claims are considered non-urgent “post-service” claims.

Medical, Dental, Vision, and Health Care Flexible Spending Account Plan and Limited Purpose Health Care Flexible Spending Account Plan						
Item	Urgent Care Claims	Non-Urgent “Pre-Service” Claims	Non-Urgent “Post-Service” Claims	“Concurrent Care” Decision to Reduce Benefits	Short-Term and Long-Term Disability	Life, Supp. Dependent Life, and AD&D
Time frame for Providing Notice	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan as soon as possible considering Medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account Medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan within a reasonable period of time appropriate to the Medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or the information is missing will be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	N/A

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Appealing a Claim

The following section generally describes the Plan's internal claim appeals process for the self-insured plans. The appeals processes of fully insured health plans may vary somewhat. Please see your Benefit Booklets for more information on the claim and appeal procedures for the Plan's fully insured health benefits.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair internal review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care

claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in Appendix C. If you don't appeal on time, you lose your right to later object to the decision.

Coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if Medical judgment is involved). Where the adverse determination is based in whole or in part on a Medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or Medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not

reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed. The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the chart in the Time Frames for Internal Appeals Process section below.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 46. For Urgent Care Claims, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are 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 description of your right to bring a civil action under ERISA following an adverse determination on review;
- For health and disability claims, if any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For health and disability adverse determinations based on Medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The health care provider;
- The claim amount (if applicable); and
- The denial code.

For Medical claims, the notice will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "Medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Time Frames for Internal Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply.

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the Plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent Care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to “days” mean calendar days.

Any lawsuit or other action brought by, or on behalf of, a claimant for Plan benefits must be filed not later than three years following the completion of the Plan's claims procedures (including, if applicable, external review).

Medical, Dental, Vision, and Health Care Flexible Spending Account Plan and Limited Purpose Health Care Flexible Spending Account Plan					
Item	Urgent Care Claims*	Non-Urgent “Pre-Service”	Non-Urgent “Post-Service”	Short-Term and Long-Term Disability	Life, Supp. Dependent Life, and AD&D
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account Medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to Medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period of time, but not later than 60 days after receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period “tolled” until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an Urgent Care, Pre-Service, or Post-Service claim, depending on the facts.

Subrogation and Acts of Third Parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (Medical and dental) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies (and any and all property acquired with such monies) paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section - through a judgment, settlement or otherwise -when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over after the Plan has been repaid in full, you may keep it. This Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a recovery unless you have been "made whole" with regard to illness or injury that is the responsibility of a third party.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds. This Plan expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, Medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this document.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.
- Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
- Not settle or release, without the prior consent of the Plan, any claim to the extent that you may have recovery rights against any third party

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Parties" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Parties" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other individual or organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered.

Coordination of Benefits

Coordination of benefits sets out rules for the order of payment of covered charges when two or more plans, including Medicare, are paying. The coordination of benefits rules apply to the Medical, Dental, and Voluntary Vision benefits. When an individual is covered by this Plan and one or more other plans, the plans will coordinate benefits when a claim is received. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to one hundred (100%) percent of the total amount payable under this Plan. Please see the coordination of benefits sections of the applicable Benefit Booklets for information on how your benefits under this Plan will be coordinated with other plan coverage.

Non-Assignment of Benefits

The right of any covered person to receive any benefits or payments under this Plan shall not be alienable by such person by assignment or any other method and shall not be subject to claims by the covered person's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

Nothing express or implied in this Plan Document and Summary Plan Description shall confer any right or benefit under this Plan upon any party other than a covered person.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Medicaid Coverage

A covered person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such covered person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the covered person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits that are payable under the Plan.

HIPAA Privacy and Security Provisions

The Plan shall comply with the standards for privacy of protected health information as set forth in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") Privacy Standards (Subpart E of 45 CFR Part 164), the security standards for the protection of Electronic PHI (defined below) as set forth in the HIPAA Security Rule (Subpart C of 45 CFR Part 164), and the notification requirements for breaches of unsecured PHI under the HIPAA Breach Notification Rule (Subpart D of 45 CFR Part 164).

Certain authorized individuals of the Company's workforce perform services in connection with administration of the Plan. To perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below). Under the Privacy Standards, these employees are permitted to have such access subject to the following:

General

The Plan shall not disclose Protected Health Information to any authorized individual of the Company's workforce unless each of the conditions set out in this HIPAA Privacy & Security Section is met. "Protected Health Information" (PHI) shall have the same definition as set out in the Privacy Standards and generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

Permitted Uses and Disclosures for Plan Administration

PHI disclosed to authorize individuals of the Company's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards. Generally, "payment" is defined as any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits under the Plan. "Health care operations" include activities related to payment and plan administration. Plan administration functions do not include employment-related functions or functions in connection with other benefit plans.

Prohibition on Use or Disclosure of Genetic Information for Underwriting Purposes

Notwithstanding any other provision of the Plan, the Plan shall not use or disclose PHI that is genetic information for underwriting purposes.

Authorized Employees

The Plan shall disclose PHI only to Authorized Individuals of the Company's workforce who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for these persons to perform Plan administrative functions. "Authorized Individuals of the Company's workforce" include the following:

- Employees working in the Employee Benefits Department
- Employees in the Information Technology Department who support the Employee Benefits Department.

Updates Required

The Company shall amend the Plan promptly with respect to any changes in the authorized individuals of an Company's workforce who are authorized to receive PHI.

Use and Disclosure Restricted

An authorized individual of the Company's workforce who receives PHI shall use or disclose the PHI only to the extent necessary to perform his or her duties with respect to the Plan's administrative functions.

Resolution of Issues of Noncompliance

In the event that any authorized individual of the Company's workforce uses or discloses PHI other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- Mitigating any harm caused by the breach, to the extent practicable; and
- Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Certification of Company

The Company must provide certification to the Plan that it agrees to—

- Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Company with respect to such information;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- Make available PHI to individual Plan covered individuals in accordance with Article 164.524 of the Privacy Standards;
- Make available PHI for amendment by individual Plan covered individuals and incorporate any amendments to PHI in accordance with Article 164.526 of the Privacy Standards;
- Make available the PHI required to provide any accounting of disclosures to individual Plan covered individuals in accordance with Article 164.528 of the Privacy Standards;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and ensure the adequate separation between the Plan (including authorized individuals of the Company's workforce) and the Company, as required by Article 164.504(f)(2)(iii) of the Privacy Standards.

Compliance With HIPAA Security Standards

If the Company creates, receives, maintains, or transmits any Electronic PHI on behalf of the Plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a HIPAA-compliant authorization, which are not subject to these restrictions), the Company will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and Company (i.e., the firewall) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware, as follows: Company will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Company will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

“Electronic PHI” means PHI that is transmitted by or maintained in electronic media.

Administrative Information

Below is key information you need to know about this Plan:

Plan Name	Sprouts Farmers Markets Holdings, LLC Employee Benefit Plan
Plan Number	501
Plan Sponsor	Sprouts Farmers Markets Holdings, LLC
Employer Identification Number	45-1076258
Plan Administrator	Sprouts Farmers Markets Holdings, LLC 5455 E. High Street, Suite 111 Phoenix, AZ 85054 Phone: 480-385-2300
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 to December 31
Plan Type	<p>Welfare benefit plan providing the following types of benefits:</p> <ul style="list-style-type: none"> • Medical/prescription drug • Dental • Voluntary Vision • Employee Assistance Plan • Short-Term Disability (STD) • Voluntary Short-Term Disability (VSTD) • Voluntary Long-Term Disability (LTD) • Supplemental Life Insurance • Supplemental Dependent Life Insurance • Basic Accidental Death and Dismemberment (AD&D) • Voluntary AD&D • Group Hospital Indemnity • Group Critical Illness • Group Accident • Pre-paid Legal/ID • My Wellbeing Program • Pre-Tax Premium Payment • Health Care Flexible Spending Account • Limited Purpose Health Care Flexible Spending Account

	<ul style="list-style-type: none"> • Dependent Care Flexible Spending Account • Pre-Tax Health Savings Account Contributions
<p>Source of Contributions</p>	<p>Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by Company contributions out of its general assets, contributions by the employee, or will be shared by the Company and the employee. The cost of the HMO, PPO, and HDHP Medical and Dental coverage are shared by the Company and the employees enrolled in those coverages. Employees pay 100% of the cost of coverage under the MEC medical plan (Employee Groups 3, 4). The Company pays 100% of the cost of the EAP, My Wellbeing Program, Basic Life (Employee Groups 1, 2) Basic AD&D (Employee Groups 1, 2), and Short Term Disability (Employee Groups 1, 2). Employees and the company share the cost of Voluntary Vision (Employee Groups 1, 2) and Voluntary Long-Term Disability (Employee Groups 1, 2). Employees pay 100% of the Supplemental Life (Employee Groups 1, 2), Supplemental Dependent Life (Employee Groups 1, 2), Voluntary AD&D (Employee Groups 1, 2), Pre-Paid Legal/ID and contributions to the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account and Dependent Care Flexible Spending Account, Group Accident Insurance, Group Critical Illness Insurance, Group Hospital Indemnity, and Voluntary Short-Term Disability (Groups 3,4). Where the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan.</p> <p>The Plan Administrator will notify employees annually as to what the employee contribution rates will be. The Company, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Company for its contributions, unless otherwise provided in that group insurance contract or required by applicable law.</p>

Plan Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nevertheless, the Company reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan or any part of the Plan at any time for any reason.

Any amendment, termination or other action by the Company will be done in accordance with the Company’s normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law.

In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan shall terminate unless the Plan is continued by a successor to the Company.

To the extent that any Plan assets remain, they will be used for the benefit of Plan participants and beneficiaries in accordance with ERISA. If surplus assets remain after all liabilities have been paid, such surplus shall revert to the Company to the extent permitted under applicable law.

Plan Administration

The Company is responsible for the general administration of the Plan, and will be the named fiduciary to the extent not otherwise specified in this document or in a Benefit Booklet. The Company, as Plan Administrator, has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Plan Administrator will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor the Company will be liable in any manner for any determination made in good faith.

The Plan Administrator may designate other organizations or persons to carry out specific fiduciary responsibilities in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Administrator will administer the Plan on a reasonable and nondiscriminatory basis, and shall apply uniform rules to all persons similarly situated.

Power and Authority of the Insurance Company

The Medical HMO, Vision, Basic Life Insurance, Supplemental Life Insurance, Supplemental Dependent Life Insurance, Basic AD&D, Voluntary AD&D, EAP, Hospital Indemnity, MEC plan, Accident, Critical Illness, Voluntary STD and LTD benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between the Company and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the Claims Administrator and fiduciary with respect to these claims and responsible for paying such claims.

With regard to the insured benefits, the insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan 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 Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor 200
Constitution Avenue N.W.
Washington, DC 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.

This Sprouts Farmers Markets, LLC Employee Benefit Plan Document and SPD is hereby adopted this _____ day of _____, 2019.

By:

Signature

Name

Title

Appendix A - Benefit Booklets

This summary should be read in combination with the insurance contracts, member hand books, certificates of coverage or evidence of coverage documents (together and individually referred to as “Benefit Booklets”) provided by the insurance companies and service providers. These Benefit Booklets are incorporated into this Plan by reference.

The Benefit Booklets are intended to describe the benefits available to you as an employee of Sprouts Farmers Markets Holdings, LLC, and, when read with this document, are intended to meet ERISA’s plan document and SPD requirements.

The Benefit Booklets include the name and address of each insurer or administrator responsible for the financing or administration of all benefits provided by this Plan. Please see the Benefit Booklets for details of Plan benefits.

For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

Coverage	Benefit Booklet Name
Medical HMO	Kaiser Permanente Evidence of Coverage
Medical PPO and HDHP	UnitedHealthcare PPO Plan - Benefit Plan Booklet- \$1,500 Plan-Premium UnitedHealthcare HDHP Design - Benefit Plan Booklet - \$2,000 Plan-Premium
Dental PPO	Sprouts Farmers Markets Holdings, LLC Preferred Dental Plan Booklet Sprouts Farmers Markets Holdings, LLC Basic Dental Plan Booklet
Employee Assistance Plan	Magellan certificates
Voluntary Vision	Avesis Group Insurance Certificate Providing Limited Benefits for Vision Care
Basic Life Insurance Supplemental Life Insurance Supplemental Dependent Life Insurance Basic Accidental Death and Dismemberment (AD&D) Voluntary AD&D	Unum Life Insurance Company of America Certificates of Insurance
Group Accident Insurance Group Critical Illness Insurance Group Hospital Indemnity	Unum Life Insurance Company of America Certificates of Insurance

Voluntary Short-Term Disability (VSTD)	Unum Life Insurance Company of America Certificates of Insurance
Short-Term Disability (STD) Voluntary Long-Term Disability (LTD)	Unum Life Insurance Company of America Certificates of Insurance
My Wellbeing	Limeade – Sprouts Farmers Markets Benefits Guide

Appendix B – Insurance Policy Issuers and Contract Administrators

Insurance Policy Issuer/Contract Administrator	Contract/Group No.	Type of Benefit
Avesis Incorporated	10790-2153	Voluntary Vision
Kaiser Foundation Health Plans, Inc. Northern California Region	603599	Medical – HMO
Kaiser Foundation Health Plans, Inc. Southern California Region	230387	Medical – HMO
Magellan Behavioral Health, Inc.	SPRT0-001	Employee Assistance Program (EAP)
Limeade	Sprouts	My Wellbeing Program
LegalShield	Sprouts	Pre-paid Legal
Unum Life Insurance Company of America	0122993	Basic Life/AD&D Supplemental Life/AD&D Voluntary Long-Term Disability (LTD) Insurance

Insurance Policy Issuer/Contract Administrator	Contract/Group No.	Type of Benefit
Unum Life Insurance Company of America	R0383497	Group Accident Insurance, Group Critical Illness Insurance, Group Hospital Indemnity
Unum Life Insurance Company of America	909266 001	Voluntary Short-Term Disability (STD)
Wageworks	SPROUTS	COBRA Administration
UnitedHealthcare	24779	Medical – PPO, HDHP
Reliance	Medical Group Number - BCM003962 Medical Group Number - BCM003963 Essential Plan Group Number - BEC003964	Medical – minimum essential coverage (MEC)
Optum Bank	915187	HSA Custodian
Metropolitan Life Insurance Company – MetLife Preferred and Basic Plans	312031	Dental – PPO (Preferred and Basic Plans)
WageWorks	33849	Health and Dependent Care Flexible Spending Accounts

Appendix C – Component Plans Claims and Appeals Contact Information

Contract Administrator	Contact Information <i>(Use Address and Phone Number on ID Card if different)</i>		
Avesis Incorporated (Vision)	<p>Attn: Vision Claims Department Avesis Incorporated P.O. Box 7777 Phoenix, AZ 85011-7777 Phone: (800) 522-0258 Fax: (602) 240-9100</p>		
Kaiser Foundation Health Plans, Inc. (Medical HMO)	<table border="0"> <tr> <td data-bbox="602 699 1003 1014"> <p>Attn: Claims Department Kaiser Permanente P.O. Box 7004 Downey, CA 90242-7004 Members Phone: (800) 464-4000 Claims Phone: (800) 390-3510</p> </td> <td data-bbox="1003 699 1443 1014"> <p><i>Grievances and Appeals:</i> Attn: Special Services Unit Kaiser Permanente P.O. Box 7136 Pasadena, CA 91109 Expedited review: (888) 987-7247 Fax: (888) 987-2252</p> </td> </tr> </table>	<p>Attn: Claims Department Kaiser Permanente P.O. Box 7004 Downey, CA 90242-7004 Members Phone: (800) 464-4000 Claims Phone: (800) 390-3510</p>	<p><i>Grievances and Appeals:</i> Attn: Special Services Unit Kaiser Permanente P.O. Box 7136 Pasadena, CA 91109 Expedited review: (888) 987-7247 Fax: (888) 987-2252</p>
<p>Attn: Claims Department Kaiser Permanente P.O. Box 7004 Downey, CA 90242-7004 Members Phone: (800) 464-4000 Claims Phone: (800) 390-3510</p>	<p><i>Grievances and Appeals:</i> Attn: Special Services Unit Kaiser Permanente P.O. Box 7136 Pasadena, CA 91109 Expedited review: (888) 987-7247 Fax: (888) 987-2252</p>		
Magellan Behavioral Health, Inc. (Employee Assistance Program)	<p>Attn: Member Services Magellan Behavioral Health, Inc. 14100 Magellan Plaza Maryland Heights, MO 63043 Phone: (800) 424-4039</p>		
Unum (Short-Term Disability & Long-Term Disability)	<p>Use address as noted on initial claim form</p>		
Unum Life Insurance Company of America (Life Insurance)	<p>Attn: Benefits Center UNUM P.O. Box 100196 Columbia, SC 29202-9975 Phone: (800) 421-0344 Fax: (800) 447-2498</p>		

Contract Administrators	Contact Information <i>(Use Address and Phone Number on ID Card if different)</i>	
UnitedHealthcare (PPO and HDHP Medical)	Attn: Claims Department UnitedHealthcare PO Box 30555 Salt Lake City, UT 84130 1-877-842-3210	<u>Grievances and Appeals:</u> UnitedHealthcare: Appeals P.O. Box 30432 Salt Lake City, Utah 84130-0432
Reliance (Minimum Essential Coverage Medical)	Attn: Claims Department RSL Specialty Products Administration 505 S. Lenola Road, Suite 231 Moorestown, NJ 08057 1-866-375-0775	
Metropolitan Life Insurance Company (MetLife Preferred and Basic Plans)	Attn: Dental Claims MetLife P.O. Box 981282 El Paso, TX 79998-1282 Phone: (800) 275-4638 Fax: (859) 389-6505	
WageWorks (Flexible Spending Accounts)	Attn: Claims Administration WageWorks P.O. Box 14053 Lexington, KY 40512 Phone: (855) 774-7441 Fax: (877) 353- 9236	<u>Grievances and Appeals:</u> Attn: Appeals and Grievances Wage Works P.O. Box 991 Mequon, WI 53092 Phone: (855) 774-7441 Fax: (877) 220-3248
Limeade (My WellBeing Program)	Limeade Customer Support Phone: (844) 650-6005 E-mail: support@limeade.com	
LegalShield (Pre-paid Legal)	Pre-paid Legal Casualty, Inc. One Pre-Paid Way P.O. Box 145 Ada, OK 74820 Phone: (800) -654-7757	

Appendix D – Look-Back Measurement Policy for Identifying Eligible Employees

The Plan Sponsor adopts this Policy for identifying Eligible Employees with respect to the Plan. All Employees who are determined to work at least 28 Hours of Service per month as set forth below are Eligible Employees under the Plan. This Policy is established as a part of the Plan and may be modified or amended in the same manner as the Plan.

Plan Sponsor Elections

Election to Use Look-Back Measurement for Certain Categories

The Plan Sponsor elects to use the Look-Back Measurement Method for Employees classified as Group 1, Groups 2, 3, and 4, for purposes of identifying Eligible Employees under the Plan.

Election of Standard Measurement Period

The Standard Measurement Period is a 12-month period beginning October 4 each year and ending the following October 3.

Election of Standard Stability Period

The Standard Stability Period is the 12-month period beginning January 1 each year and ending the following December 31. The same Standard Stability Period applies with respect to Employees who are determined to be Eligible Employees during the Standard Measurement Period and Employees who are determined not to be Eligible Employees during the Standard Measurement Period.

Election of Standard Administrative Period

The Standard Administrative Period is the period beginning on October 4 each year and ending the following December 31.

Election of Initial Measurement Period

With respect to a New Employee, the Initial Measurement Period is the 11-month period beginning on the first day of the calendar month following the Employee's Start Date.

Election of Initial Stability Period

With respect to a New Employee, except as provided under "*Transition to Ongoing Employee*," the Initial Stability Period is the 12-month period beginning on the first day of the second calendar month after the end of the Initial Administrative Period.

Election of Initial Administrative Period

With respect to a New Employee, the Initial Administrative Period means all periods of time between the Employee's Start Date and the beginning of the Employee's Initial Stability Period other than the Employee's Initial Measurement Period.

Taking Special Unpaid Leave Into Account

For purposes of determining an Employee's average Hours of Service during a Measurement Period, the average Hours of Service for that Measurement Period are determined by computing the average after excluding any periods of Special Unpaid Leave during that Measurement Period and by using that average as the average for the entire Measurement Period.

Identification of Full-Time Employees and Eligible Employees

Ongoing Employees

Employees Determined to Be Eligible. An Ongoing Employee who is determined to be an Eligible Employee during a Standard Measurement Period will be considered an Eligible Employee, for each calendar month during the Standard Stability Period associated with that Standard Measurement Period.

Employees Determined Not to Be Eligible. An Ongoing Employee who is determined not to be an Eligible Employee during a Standard Measurement Period will not be considered an Eligible Employee, for any calendar month during the Standard Stability Period associated with that Standard Measurement Period.

New Employees

New Employees. A New Employee who is reasonably expected at his or her Start Date to work at least 28 hours per week (and is not a Seasonal Employee) is considered an Eligible Employee, beginning on the Employee's Start Date.

Factors for Determining Eligible Employee Status. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee who is not a Seasonal Employee is reasonably expected at his or her Start Date to work at least 28 Hours of Service per week:

- Whether the Employee is replacing an Employee who was (or was not) working at least 28 Hours of Service per week.
- The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 28 Hours of Service per week during recent Measurement Periods.
- Whether the job was advertised or otherwise communicated to the Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average more or less than 28 Hours of Service per week.

Transition to Ongoing Employee. Once a New Employee who is an Eligible Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as an Eligible Employee is governed by the provisions of this Policy regarding Ongoing Employees.

New Employees. A New Employee who, based on the facts and circumstances at the time of hire is not expected to work at least 28 Hours of Service per week, is not initially considered an Eligible Employee and will have Hours of Service measured over an Initial Measurement Period and be treated as follows:

- *Eligible After Initial Measurement Period.* If a New Employee is determined to be an Eligible Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will be considered an Eligible Employee, for each calendar month during the Employee's Initial Stability Period.

- *Not Eligible After Initial Measurement Period.* If a New Employee is determined not to work at least 28 Hours of Service per week during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will not be considered an Eligible Employee, during the Employee's Initial Stability Period, except to the extent provided under the provisions of this policy regarding Ongoing Employees.
- *Change in Status During the Initial Measurement Period.* Notwithstanding the foregoing, if a New Employee who is a Seasonal Employee or Variable-Hour Employee experiences a change in employment status before the end of the Employee's Initial Measurement Period such that if the Employee had begun employment in that new status the Employee would have reasonably been expected to work at least 28 Hours of Service per week (and not a Seasonal Employee or Variable-Hour Employee), the Employee will be considered an Eligible Employee, beginning on the first day of the calendar month after the change in the Employee's employment status or, if earlier, at the beginning of the Employee's Initial Stability Period, if the Employee is determined to be working at least 28 hours per week during the Employee's Initial Measurement Period.

Transition to Ongoing Employee. Once a New Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as an Eligible Employee, is governed by the provisions of this Policy regarding Ongoing Employees, but subject to the following:

- *Eligible During the Initial Measurement Period but Not the First Standard Measurement Period.* If the Employee is determined not to be an Eligible Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will continue to be considered an Eligible Employee, for each calendar month during the Initial Stability Period, if the Employee was determined to be an Eligible Employee during the Employee's Initial Measurement Period.
- *Eligible During the First Standard Measurement Period but Not During the Initial Measurement Period.* If the Employee is determined to be an Eligible Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will be considered an Eligible Employee, for each calendar month during the entire Standard Stability Period associated with the Employee's first Standard Measurement Period, even though that Standard Stability Period may overlap an Initial Stability Period associated with an Initial Measurement Period during which the Employee was determined not to be an Eligible Employee.
- *Eligible During Both the Initial Measurement Period and the First Standard Measurement Period.* If the Employee is considered an Eligible Employee, during both the Employee's Initial Stability Period and the Employee's first Standard Stability Period, the Employee will be considered an Eligible Employee, during any period between the end of the Initial Stability Period and the beginning of the Employee's first Standard Stability Period.

Rehired Employees

An Employee who is terminated and rehired into the same Employee classification will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the Controlled or Affiliated Group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding Period of Employment. For purposes of applying these rehire rules, the duration of the Period of Employment immediately preceding a

period during which an Employee was not credited with any Hours of Service is determined after application to that Period of Employment of the rules on Special Unpaid Leave, if and to the extent those rules are applicable.

An Employee who is terminated and rehired into a different Employee classification will be treated according to the rules for that Employee classification.

Definitions

For purposes of this Policy, the following terms have the following meanings:

“Administrative Period” means a Standard Administrative Period or an Initial Administrative Period.

“Controlled or Affiliated Group” means the group of organizations consisting of the Plan Sponsor and any other organization that is part of a controlled group or affiliated service group with the Plan Sponsor within the meaning of Code §414(b), (c), (m), or (o).

“Eligible Employee” means an Employee that is determined to be working at least 28 Hours of Service per week.

“Employee” has the meaning set forth in the Plan.

“Employer” means the Plan Sponsor and any other member of the Controlled or Affiliated Group that has adopted this Plan for the benefit of the Employer’s employees.

“Hour of Service” means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR §2530.200b-2(a)).

- The term “Hour of Service” does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code §§861 through 863 and the regulations thereunder.
- An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or Affiliated Group.
- Hours of Service for all Employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due.

“Look-Back Measurement Method” means the method of identifying Eligible Employees as described in Treas. Reg. §54.4980H-3(d), as amended or supplemented.

“Measurement Period” means an Initial Measurement Period or a Standard Measurement Period.

“New Employee” means an Employee who has been employed for less than one complete Standard Measurement Period.

“Ongoing Employee” means an Employee who has been employed for at least one complete Standard Measurement Period.

“Period of Employment” means the period of time beginning on the first date for which an Employee is credited with an Hour of Service for an Employer or any member of the Controlled or Affiliated Group and ending on the last date on which the Employee is credited with an Hour of Service for that Employer or any member of the Controlled or Affiliated Group, both dates inclusive. An Employee may have one or more Periods of Employment with the same Employer.

“Seasonal Employee” means a New Employee who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year.

“Special Unpaid Leave” means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

“Start Date” means the first date on which an Employee is credited with an Hour of Service with the Employer or a member of the Controlled or Affiliated Group.

“Variable-Hour Employee” means a New Employee if, based on the facts and circumstances at the Employee’s Start Date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 28 Hours of Service per week during the Initial Measurement Period because the Employee’s hours are variable or otherwise uncertain. For purposes of determining whether an Employee is a Variable-Hour Employee, the Employer may not take into account the likelihood that the Employee may terminate employment before the end of the Initial Measurement Period. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Variable-Hour Employee:

- Whether the Employee is replacing an Employee who was a Full-Time Employee or a Variable-Hour Employee.
- The extent to which the Hours of Service of employees in the same or comparable positions have actually varied above and below an average of 28 hours of service per week during recent Measurement Periods.
- Whether the job was advertised or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 28 hours of service per week, average less than 28 hours of service per week, or might vary above and below an average of 28 hours of service per week.

Terms Defined in the Plan

Capitalized terms not specifically defined in this Policy have the meanings set forth in the Plan.

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