RETA PLAN

SUMMARY PLAN DESCRIPTION

Medical and Hospitalization Benefits

Mental Health and Substance Use Disorder Benefits

Prescription Drug Benefits

IMPORTANT NOTICE: This Summary Plan Description identifies and describes group health plan medical benefit programs that may be available to you and also provides other important information. Detailed Benefit Booklets and Summaries of Benefits and Coverage for the benefits under the several different coverage options available to you supplement this Summary Plan Description. All of them are available to any Participant or beneficiary who so requests them. You may also access them online through the Reta Benefits Center at retatrust.org/public or make a request for them by telephone to the Reta Member Help Desk at 877-303-7382.

Basic Information About the Reta Plan

Name of Plan: Reta Plan

Different Benefit Programs: This Summary Plan Description is for the Reta Plan's group health plan medical benefit programs, which include medical and hospitalization, mental health and substance use disorder, and prescription drug benefits. The names of the different benefit programs under the Reta Plan are shown in the section below entitled "Contact Information for the Claims Administrators."

Plan Sponsor: Reta Trust
2121 North California Boulevard, Suite 350
Walnut Creek, CA 94596

The Reta Trust is a California business trust that holds the funds and other assets used to pay the benefits under the Reta Plan. Constituent members of the Reta Trust are all agencies, instrumentalities, or educational, charitable, and religious institutions operated by the Roman Catholic Church in the United States. Each constituent member of the Reta Trust, called a "Trustor," is under the general supervision or control of the Roman Catholic Church in the United States and is listed in or approved for listing in the *Official Catholic Directory*.

Trustors: A complete list of the Trustors may be obtained by Participants and beneficiaries upon written request to the Administrator and is also available for examination by Participants and beneficiaries.

Plan Sponsor's IRS Employer Identification Number: 94-2329720

Plan Number: 501

Type of Plan: The Reta Plan is an employee welfare benefit plan and a group health plan.

Type of Administration: Benefits under the medical group health plan coverages available through the Reta Plan are administered by the Reta Trust and through contracts with third parties. These third parties include insurance companies that serve as Claims Administrators, but do not serve as insurers for the Reta Plan. The Claims Administrators have been hired to provide several types of services, including the processing and adjudication of claims and appeals, medical management, and access to networks of health care providers. Other administrative services are provided under contracts with Gallagher Benefit Services, Inc. and Benefit Allocation Systems, LLC (BAS). The Reta Trust is ultimately responsible for providing the benefits under the Reta Plan.

Plan Year: The Plan Year begins on each July 1 and ends the following June 30.

Administrator: Reta Trust
2121 North California Boulevard, Suite 350
Walnut Creek, CA 94598
877-303-7382

Trustees:

Tom Schadle
CFO
Roman Catholic Diocese of Tulsa
12300 E. 91st Street South
Broken Arrow, OK 74012

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1505 E. Mesquite Lane
Victoria, TX 77901

Laura Huber
Finance Officer
Diocese of Bismarck
520 N. Washington St.
P.O. Box 1137
Bismarck, ND 58502

Tom J. McNamara
CFO
Diocese of Sacramento
2110 Broadway
Sacramento, CA 95818

Plan's Agent for Service of Legal Process: The agent for service of legal process with respect to the group health coverages is the Reta Trust, which is both the Plan Sponsor and Administrator. The address for the Reta Trust is listed above.

Reta Member Help Desk Contact Information

Benefits Inquiries and Issue Resolution: Telephone: 877-303-7382
Email: service@retaenroll.org

Contact Information for Claims Administrators

Each Trustor participating in the Reta Trust makes its own choices as to which particular benefit programs and coverage options under the Reta Plan will be available to its own Employees and their dependents. As a consequence, the coverage options administered by Kaiser Permanente may not be available to you.

Blue Shield of California	Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540 Website: engagementpoint.com Telephone: 888-772-1076
CVSCaremark (Pharmacy Benefit Manager for Blue Shield of California Coverage Options)	CVS Caremark Customer Care Correspondence P.O. Box 6590 Lee's Summit, MO 64064-6590 Website: Caremark.com Telephone: 800-552-8159 Website for Specialty Drugs: CVSSpecialty.com
Kaiser Permanente (Medical and Pharmacy)	Kaiser Foundation Health Plan One Kaiser Plaza, 12th Floor, Suite 1223 Oakland, CA 94612 Website: www.kp.org Telephone: Northern California Region: 800-663-1771 Southern California Region: 800-533-1833 Colorado Region: 877-883-6698 Northwest Region: 866-800-3402

Online Reta Benefit Center

You may access information about your group health plan coverage online at the following website: https://retatrust.org/public.

Contact Information for COBRA Administration

Information pertaining to continuation coverage for all benefit programs is described in Section 14 of this booklet entitled "Continuation Coverage Rights Under COBRA for Both Employees and Dependents." Continuation coverage is either administered by Benefits Allocation System, LLC (BAS) or by your Trustor.

BAS can be contacted for information concerning whether BAS or your Trustor administers COBRA continuation coverage. The contact information for BAS is as follows:

Benefits Allocation System, LLC (BAS)
640 Freedom Business Center, Suite 300
King of Prussia, PA 19406

Telephone: 800-945 5513
Website: http://www.basusa.com

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Section 1. Introduction

About the Reta Trust and the Reta Plan

The Reta Trust is a California trust that was first established in 1976 by a group of Roman Catholic dioceses and religious orders to provide group health plan coverage for their employees, clergy, and religious (all referred to as "Employees"). The Roman Catholic agencies, instrumentalities, and educational, charitable, and religious institutions that choose to participate in the Reta Trust are referred to as "Trustors." The "Reta Plan" is the name of the employee benefit plan sponsored by the Reta Trust in which the Employees and dependents of the Reta Trustors may enroll for group health plan coverage.

The Reta Plan offers coverage options that are traditional Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs). Some of PPO and EPO coverage options are high deductible health plans that are compatible with the use of a health savings account (HSA). Each Trustor can choose different coverage options to offer its Employees that differ in terms of annual deductibles, copayments, other cost-sharing provisions, and other features.

The Reta Plan is not an "insured" health plan in that it is not backed by an health insurance policy issued by an insurance company. Instead, benefits payable under the Reta Plan are paid from the assets of the Reta Trust, which consists of contributions by both the Trustors and covered Employees, plus investment earnings.

The Reta Plan is subject to the federal law known as the "Employee Retirement Income Security Act of 1974" (ERISA) and Participants and beneficiaries can enforce their rights under the Reta Plan pursuant to that federal law.

Role of Roman Catholic Teaching

Consistent with the objectives of the Trustors, the health care benefits provided by the Reta Plan are designed in a manner that complies with the Roman Catholic Church's teachings on medical and moral matters with respect to the provision of health care services. This includes consistency with the Ethical and Religious Directives for Catholic Health Care Services, as modified from time to time ("Ethical and Religious Directives").

Even if you are not Roman Catholic, or if your personal beliefs are inconsistent with Catholic teaching, the Reta Plan can only provide you with services that are consistent with the Church's teaching and the Ethical and Religious Directives. The Benefit Booklets contain statements excluding from coverage those treatments that do not meet those conditions. There are no exceptions. The Reta Plan does not pay for those treatments. For your reference, the latest (sixth) edition of the Ethical and Religious Directives published in 2018 can be found at the following webpage: https://usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_3.pdf .

About This Booklet

This booklet is a part of the written instruments under which the Reta Plan is operated. This booklet is also the "Summary Plan Description" for the group health plan medical benefit programs available under the Reta Plan and describes provides important information about the available benefits.

This Summary Plan Description is supplemented by the detailed Benefit Booklets for the different coverage options. The Benefit Booklets are incorporated by reference as parts of this Summary Plan Description. Make sure that you have or obtain a copy of the applicable Benefit Booklet for the coverage option in which you are enrolled. All of them are available without cost to any Participant or beneficiary who so requests them. You may make a request for the detailed Benefit Booklets and Summary of Benefits and Coverage to the Administrator or by calling the Reta Trust Member Help Desk telephone number.

This Summary Plan Description is not intended to constitute a contract between Trustor and any covered person. Furthermore, this Summary Plan Description is not intended as an inducement or condition of the employment of any Employee. Nothing in this Summary Plan Description is to be construed as giving to any person any right to be retained in the employ of any Trustor or as affecting in any way a Trustor's right to terminate the employment of any person, with or without cause, and regardless of the effect of such termination upon the person's right to receive benefits pursuant to the Reta Plan.

Online Reta Benefit Center

You may access information about your group health plan coverage online at the following website: https://retatrust.org/public .

Authority To Resolve Issues and Decide Claims

The Reta Trust is the Plan Sponsor. The Reta Trust is also the "Administrator" and a named fiduciary.

The Administrator has delegated certain of its responsibilities over claims for benefits to the Claims Administrators. The Claims Administrators may make determinations on claims, including both initial and ultimate determinations on claims on appeal. In each case of the delegation, the decision of the Claims Administrator will be treated as the decision of the Administrator.

The Administrator or Claims Administrator decides claims for benefits and claims for eligibility. ***Benefits under the Reta Plan will be paid only if the Administrator or the Claims Administrator, as delegate of the Administrator, decides that the applicant is entitled to them.*** The interpretations and determinations of the Administrator or Claims Administrator are final and binding on all Participants, Employees, former Employees, their dependents and beneficiaries, and other persons, unless overturned by a court acting within its lawful jurisdiction for the reason that the Administrator or Claims Administrator has abused its discretion.

Definitions

Capitalized phrases other than names and other commonly capitalized terms have special meanings. The definitions of these phrases are set forth below.

"**Claims Administrator**" means a person or entity which carries out certain administrative functions for the Administrator, such as claims processing, claims adjudication, and utilization review. A Claims Administrator may also provide access to a network of health care providers which have agreed to charge negotiated rates to patients making use of their services through the network. The Claims Administrators are listed at the front of this booklet in the section entitled "Contact Information for Claims Administrators."

"**Employee**" means an individual employed by a Trustor, excluding an independent contractor who is not a member of Roman Catholic clergy or a member of a Roman Catholic religious order. As used in this Summary Plan Description, the term "Employee" also includes clergy and members of religious orders whose relationship with a Trustor is not usually referred to as "employment" under state or federal law.

"**Reta Benefit Center**" means the online portal allowing Participants access to information about their selected coverage options and the completion of enrollment processing.

"**Participant**" means an Employee of a Trustor (or former Employee where called for by the context) who is eligible to enroll in a coverage option under the Reta Plan, has met the terms and conditions for coverage, and has paid, is paying, or is committed to payment the required contributions, if any, for the coverage option selected. Not all Employees are eligible to enroll in a coverage option under the Reta Plan and become Participants.

"**Trustor**" means one of the agencies, instrumentalities, or educational, charitable, or religious institutions operated by the Roman Catholic Church in the United States that is a constituent member of the Reta Trust.

"**Plan Year**" means each period beginning July 1 and ending the next following June 30.

"**Administrator**" means the Reta Trust.

"**Plan Sponsor**" means the Reta Trust.

Where To Direct Questions

Questions for general information may be directed to the Reta Trust Member Help Desk telephone number. If you have specific questions pertaining to benefits under the particular coverage option in which you are enrolled or the status of a claim, you should direct your inquiry to the appropriate Claims Administrator listed at the front of this Summary Plan Description.

Questions about your eligibility as an Employee or the eligibility of your spouse or children should be directed to your Trustor's human resources staff**.**

Aside from information about the enrollment eligibility of Employees, spouses, and children, the only authorized sources of information about the benefit programs and coverage options available under the Reta Plan are the Reta Trust Member Help Desk and the Claims Administrators. ***You may not rely on any other person, such as a supervisor, human resources staff member, or a co-worker for benefit information about the Reta Plan or any benefit program or coverage option under the Reta Plan.***

Section 2. Right to Change or Terminate the Reta Plan

Plan Sponsor's Authority to Change, Eliminate, or Terminate Benefits

The Plan Sponsor reserves the right to make from time to time any changes or amendments to the written instruments governing the Reta Plan, including this Summary Plan Description. Changes may be made to eliminate certain benefits or to otherwise limit the benefits that remain available under the Reta Plan. Changes necessary or desirable to comply with applicable law may be made with or without retroactive effect.

Changes may also be made to increase the share of the costs of benefits that are required of Participants, such as monthly premiums (including the Participant's payroll deduction), deductibles, co-insurance, and co-payments.

The Plan Sponsor may also terminate the Reta Plan at any time. In addition, the Reta Plan will automatically terminate on any one or more of the following events:

- If the Plan Sponsor is legally dissolved.
- If the Plan Sponsor makes a general assignment for the benefit of its creditors.
- If the Plan Sponsor files for liquidation under applicable laws.
- If the Plan Sponsor merges or consolidates with any other entity and it is not the surviving entity, or if the Plan Sponsor sells or transfers substantially all of its assets, or if it goes out of business, unless the successor in interest of the Plan Sponsor expressly agrees to assume the liabilities under the Reta Plan.

Rights of Participants and Beneficiaries on Plan Termination

Upon termination of the Reta Plan, the Administrator will determine the amounts required to fully pay all claims and other liabilities to Participants and beneficiaries as of the date of termination. The unpaid claims for benefits incurred prior to the termination date shall become payable to Participants and beneficiaries to the extent funded and as the Administrator may direct. After payment of all claims for benefits and expenses of the Reta Plan have been made, any remaining assets of the Reta Plan shall revert to and belong to the Trustors of the Reta Trust.

Section 3. General Information About Benefits

What Types of Benefits Are Provided

The Reta Plan provides the following types of benefits:

- **Medical and hospitalization benefits, including surgical benefits and mental health and substance abuse disorder benefits.**

- **Prescription drug benefits.**

Each Participant receives a combination of medical and hospitalization benefits, mental health and substance use disorder benefits, and prescription drug benefits as integrated parts of his or her group health plan coverage option. That is, if you choose to enroll in the Reta Plan as a Participant in order to receive medical and hospitalization benefits, you will also receive prescription drug benefits and mental health and substance use disorder benefits. The combined cost of coverage for all of the group health plan medical benefits is included in the monthly amount you pay for participation in the Reta Plan. In other words, you may not elect only medical and hospitalization benefits in exchange for a lower premium that does not include the cost of the other coverages.

Benefit Programs and Coverage Options

The Reta Plan offers two different benefit programs for group health plan coverage. One of the benefit programs is administered by Blue Shield of California as Claims Administrator, with prescription drug benefits administered by CVSCaremark.

The other benefit program is administered by Kaiser Permanente Insurance Co. ***Some Trustors do not offer, or cannot offer for geographical reasons, the benefit program administered by Kaiser Permanente.***

Within each benefit program, each Trustor can offer to its Employees different "coverage options." A coverage option has a specific combination of annual deductibles (if any), copayments, coinsurance obligations, and limits on access to out-of-network providers.

Role of and Services Provided by the Claims Administrators

The Claims Administrators do not themselves provide health care. Rather, they administer the benefit programs under the Reta Plan on behalf of the Administrator. In that regard, the Claims Administrators perform the following functions:

- The Claims Administrators administer networks of providers of medical and hospital services, mental health and substance use disorder services, and pharmacy services. These networks offer access to health care and prescription drugs at negotiated rates.

- The Claims Administrators make decisions to authorize treatment when preauthorization for the treatment is required by the applicable Benefit Booklet.

- They provide managed care services. This means they make decisions as to the appropriateness and duration of particular treatments that may be proposed by your doctor or other health care provider.

- The Claims Administrators process and adjudicate your claims for benefits.

- The Claims Administrators make decisions on any appeals of claim denials you may make, other than claims for eligibility to participate in the Reta Plan.

How To Access Directories of Network Providers

Both of the Claims Administrators utilize networks of health care providers that have agreed to negotiated amounts to charge for services to Plan participants and dependents. The deductibles, coinsurance, copayments, and maximum out-of-pocket limits may also be more favorable when the enrollee uses providers or facilities that are in-network.

Note that, if you are enrolled in a coverage option that is an EPO, i.e., an "exclusive provider organization," the Reta Plan will ***not*** pay for any services provided by out-of-network providers, except in the case of emergency care, stabilization care following an emergency, and urgent care when you are physically outside the geographical area covered by the network providers.

Providers in the two different networks are set forth in directories that can be accessed, without charge, from the website of each Claims Administrator as follows:

Blue Shield of California Network Providers:

https://www.blueshieldca.com/fad/home

Kaiser Permanente Network Providers:

https://healthy.kaiserpermanente.org/doctors-locations

Paying for Coverage

Each Participant's monthly "premium" or required contribution for the particular coverage option in which he or she is enrolled is established by his or her Trustor. Information on those contributions can be obtained from the Trustors.

Information on how you pay your required contributions and how to pay if you are still covered but not receiving a payroll check is set forth in Section 10 of this Summary Plan Description entitled "Your Required Contributions to the Reta Plan."

Extent of Insurance; How Your Benefits Are Provided

No benefits under any of the group health plan benefit programs are funded by or guaranteed under contracts or policies of insurance. Instead, benefits provided by the Reta Plan will be paid from the assets held in the Reta Trust. The funds used to pay benefits provided are derived from contributions from both Trustors and their Employees.

Section 4. Eligibility Rules: Who Can Enroll?

Conditions on Eligibility of Employees

Each Trustor establishes the eligibility rules for coverage under the Reta Plan that are applicable to its own Employees. You should contact your Trustor to find out its rules governing your eligibility as an Employee. ***An individual may not be covered under the Reta Plan both as an Employee and as the spouse of an Employee.***

As a general rule, however, you will be eligible for enrollment in the Reta Plan if you are an Employee of a Trustor residing in the United States and you work "full-time," which means that you work an average of at least 30 hours per week. Note that a Trustor can allow coverage for its part-time Employees, which are those Employees who work an average of less than 30 hours per week.

If the hours you work vary from week to week or if you only work on a seasonal basis, you may become eligible for enrollment in the Reta Plan based the special rules that apply to what are called "variable hour employees." You should contact your Trustor to find out about eligibility if you are a variable hour employee.

If you are a variable hour employee and have not been offered coverage under the Reta Plan by your Trustor, you can ask your Trustor to contact the Reta Trust to see if it is possible for you to be enrolled in the Reta Plan. You may also file a claim for benefits based on eligibility, as provided for the section of this Summary Plan Description entitled "Claims and Appeals as to Eligibility for Enrollment."

Trustor-Specific Eligibility Rules for Spouses

Each Trustor establishes the eligibility rules for coverage under the Reta Plan applicable to the spouses of Employees who are themselves eligible for enrollment. You should contact your Trustor to find out its rules governing the eligibility of your spouse. ***An individual may not be covered under the Reta Plan both as an Employee and as the spouse of an Employee.***

Conditions on Eligibility of Your Children

If you are eligible for coverage under the Reta Plan as an Employee, you may also elect coverage for your children. ***An individual may not be covered, however, both as an Employee and as dependent child of an Employee.***

Your children will remain eligible for coverage until age 26. When your child attains the age of 26, eligibility for coverage for that child ends on the last day of the month when the child turns 26.

The term "child" means any of your natural children and any of your legally adopted children. Adopted children become eligible dependents when the participant has a "legal obligation" for total or partial support of a child in anticipation of adoption of the child, as follows:

- In the case of an agency adoption, the date of adoptive placement as specified in the adoptive placement agreement.

- If the adoption involves a child who is born and resides outside of the United States, in order to demonstrate a legal obligation for total or partial support of a child in anticipation of adoption, there must be an agreement that is enforceable in a competent jurisdiction.

The Administrator has discretion to determine when a legal obligation for total or partial support of a child in anticipation of an adoption begins.

Trustor-Specific Eligibility Rules for Children

Your Trustor may allow you to enroll children other than your natural or adopted children, such as your step children, your spouse's adopted children, children for whom you or your spouse are the legal guardian, or children for whom you or your spouse are responsible by court decree for principal support or medical care.

Your Trustor may also allow you to continue coverage under the Reta Plan for a child beyond age 26 if the child is permanently and totally disabled because of a medically determinable physical or mental impairment and whose disability commenced prior to otherwise losing dependent status under the Reta Plan or a prior group health plan that covered you or your spouse.

Section 5. Normal Enrollment Rules: When Does Coverage Start?

Trustor-Specific Waiting Periods

Once you become eligible for the Reta Plan, your Trustor may impose a waiting period of up to 90 days before your first day of coverage. You should make sure you know the length of your Trustor's waiting period, if any.

Note that depending upon when you actually enroll, you may experience administrative delays with your benefits if you have not received your ID card at the time you seek medical care. This administrative delay does not affect your actual effective date of coverage.

Actively-At-Work Requirements May Not Apply

Your Trustor may impose a requirement that you must be actively at work before your first day of coverage. Even if you might be required by your Trustor to be actively at work on the date your other employee benefits to actually start, such a rule does not apply to your benefits under the Reta Plan if the reason you are not actively at work is any one or more of the following: health status, medical condition, receipt of health care, or disability. Also, any period of time during which you are not actively at work because of any of these circumstances counts as part of a waiting period imposed by your Trustor.

Annual Enrollment Periods

The annual enrollment period will be determined by the Administrator and will occur during the months preceding July 1st of each year. During the annual enrollment period if you meet the requirements for eligibility, you will be given the opportunity to elect the coverage under the coverage options then available, even if you had not previously elected coverage under any coverage option available under the Reta Plan.

Changing Between Coverage Options

As a general rule, if you wish to change from one coverage option available to you to another coverage option also available to you, you may do so only during the annual enrollment. ***This means once you elect coverage you may not opt out of one coverage option and elect a different coverage option until the next open enrollment period, unless otherwise permitted under your Trustor's rules governing changes of coverage.***

Section 6. Special Late Enrollment Periods

EXTENSION OF DEADLINES DUE TO NATIONAL EMERGENCY: The National Emergency declaration concerning the COVID-19 pandemic has resulted in an extension of several of the otherwise applicable deadlines stated in this booklet pertaining to requesting late enrollment. If you think you have missed a deadline stated in this booklet, you should telephone the Reta Member Help Desk at 877-303-7382 to find out if the extension of deadlines allows you more time than is stated in this Summary Plan Description.

In addition to the normal dates for enrolling in the Reta Plan, each eligible Employee and his or her eligible dependents have special late enrollment rights with respect to the coverage options available under the Reta Plan in the circumstances described in this section. If one of the circumstances apply, the eligible Employee may begin the enrollment process with his or her Trustor or by calling the Reta Member Help Desk and by providing documentation of entitlement to late enrollment as described in this section.

Adding New Eligible Dependents, Including Newborns

A current Employee, his or her eligible spouse, and any eligible child who becomes a new dependent of the Employee are each eligible for special late enrollment (subject to the Reta Plan's eligibility rule conditioning dependent enrollment on the enrollment of the Employee) if all of the following conditions are satisfied:

- The Employee has met the waiting period applicable to becoming enrolled and is eligible to have been enrolled (regardless of whether or not the Employee is actually enrolled); **and**

- An individual becomes an eligible dependent of the Employee through marriage, birth, or adoption, or placement for adoption.

Based on meeting the conditions listed above, an Employee not previously enrolled in coverage but eligible for coverage can elect coverage under any coverage option available to him or her under the Reta Plan upon getting and enrolling a new eligible dependent in the Reta Plan. In the case of birth or adoption of a child, other eligible dependents of the Employee are also entitled to special enrollment rights upon the birth or adoption of a child.

In the case of case a newborn or newly adopted child, the Employee must request enrollment of the child in the Reta Plan within 30 days of the child's birth or placement for adoption. Coverage under this special late enrollment period will then begin retroactively as of the date of birth, adoption, or placement for adoption for all of the eligible persons for whom enrollment was requested.

To add a spouse who is eligible under your Trustor's specific eligibility rules due to a recent marriage, the Employee must begin the process to enroll in the Reta Plan and provide documentation of the marriage. The Employee must complete the enrollment within 30 days of the date of marriage. Coverage of a recent spouse under this special late enrollment period will begin on either the first day of the payroll period following the date of the notification and request for enrollment or the first day of the month following the date of notification and request for enrollment, whichever is sooner.

If the notice and enrollment is not completed within the 30-day period, the Employee must wait until the next annual enrollment period to enroll the eligible dependent.

Change in Work Schedule

An Employee and any eligible dependents may enroll in the Reta Plan prior to the next annual enrollment period if the Employee's regularly scheduled hours increase and result in a change in eligibility under the Trustor's specific eligibility rules. Please refer to Section 4, "Eligibility Rules: Who Can Enroll?"

To obtain the benefit of this special late enrollment period, the Employee must complete the enrollment process within 30 days of the date of the change in work schedule or the Employee

will not be enrolled in coverage. If the Employee does not complete enrollment within the 30-day period, the Employee must wait until the next annual enrollment period to enroll.

Upon Loss of Other Coverage

A current Employee and any dependents are each eligible for special late enrollment (subject to the Reta Plan's rule conditioning dependent enrollment on the enrollment of the Employee) if all of the following conditions are satisfied:

- The Employee or the dependents are otherwise eligible to enroll in the Reta Plan.

- When coverage under the Reta Plan was previously offered, the Employee or dependent had coverage under another group health plan or had health insurance coverage (including, for example, Medicaid coverage).

- The other coverage was lost for one of the following reasons:

  (a) *Loss of Eligibility for Coverage*. If the other coverage was not under a COBRA or similar continuation of coverage provision, the coverage was lost as a result of loss of eligibility for the coverage. Loss of eligibility for coverage includes loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward such coverage terminated. If the Employee's coverage was offered through an HMO or other arrangement that has a service area for eligibility, loss of eligibility for coverage includes loss of coverage because an individual no longer resides, lives, or works in the HMO or other arrangement's service area (whether or not within the choice of the individual and whether or not another benefit program is available to the individual). Loss of eligibility for coverage includes a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

  (b) *Termination of Trustor Contributions*. If the other coverage was not under a COBRA or similar continuation of coverage provision, loss of coverage is deemed to occur if employer contributions toward the Employee's or dependent's coverage terminate.

  (c) *Exhaustion of COBRA Continuation Coverage*. If the other coverage was a COBRA or similar continuation of coverage provision, the coverage under such provision was exhausted. "Exhaustion" means that the coverage ceased for any reason other than either cessation for failure to pay premiums on a timely basis or cessation for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact).

- The Employee waived coverage in the Reta Plan at the most recent time of enrollment for the Employee or dependent.

To obtain the benefit of this special late enrollment period, the Employee begin the process to enroll in the Reta Plan and provide documentation showing of the loss of coverage. The Employee must complete the enrollment in the Reta Plan within 30 days of the loss of coverage.

If the Employee does not complete enrollment in the Reta Plan within 30 days of the loss of coverage, the Employee must wait until the next annual enrollment period to enroll in group health plan coverage.

Loss of Health Plan Coverage As a Result of Loss of Eligibility Under Medicaid or a State Child Health Plan

A special late enrollment period applies if the Employee or eligible dependent is otherwise eligible for coverage under the Reta Plan and the Employee or eligible dependent was covered under a Medicaid plan or under a State child health plan and experienced a termination of coverage as a result of loss of eligibility for coverage under the Medicaid plan or State child health plan.

To obtain the benefit of this special late enrollment period, the Employee begin the process to enroll in the Reta Plan and provide documentation showing of the loss of coverage. The Employee must then complete enrollment in the Reta Plan within 60 days of the loss of eligibility.

If enrollment in the Reta Plan is not completed in the 60-day period, the Employee must wait until the next annual enrollment period to make the enrollment change.

Becoming Eligible For Premium Assistance Under a Medicaid Plan or State Child Health Plan

To obtain the benefit of this special late enrollment period, the Employee must start the process to enroll in the Reta Plan and provided documentation showing eligibility for premium assistance and proof of eligibility for coverage under the Medicaid plan or State child health plan. The Employee must complete the enrollment change with the Reta Plan within 60 days of becoming eligible.

If the enrollment in the Reta Plan is not completed in the 60-day period, the Employee must wait until the next annual enrollment period to enroll.

Section 7. General Description of the Benefit Program Administered by Blue Shield of California

No Geographic Conditions on Eligibility

No geographic conditions on eligibility apply to enrollment in any of the coverage options available under the benefit program administered by Blue Shield of California.

Types of Coverage Options

Each coverage option has a specific combination of annual deductibles, copayments, coinsurance obligations, and limits on access to out-of-network providers. The several coverage options available under the benefit program administered by Blue Shield of California fall into two basic types which differ on the extent to which the Reta Plan will pay for services obtained to out-of-network health care providers:

- **PPO.** Many of the coverage options are structured as "PPOs" or "preferred provider organizations." A PPO provides access to a network of health care providers you can use for your medical care. These providers have agreed to provide services to the participants and dependents covered by the Reta Plan at special, negotiated rates. A PPO coverage option, however, offers you the choice to receive health care services from both in-network provider and out-of-network providers. This means you can see any doctor or specialist, or use any hospital, but you may have to pay higher deductibles, coinsurance percentages, and other out-of-pocket costs if you use an out-of-network health care provider.

- **EPO.** Other coverage options are called "EPOs" or "exclusive provider organizations." EPOs also provide access to a network of health care providers. Of key significance, EPOs do not cover any services provided by out-of-network providers, except for emergency care and certain other circumstances. The exceptions are for emergency care, stabilization care following an emergency, and urgent care when you are physically outside the geographical area covered by the network providers. ***This means you will not, unless it is for emergency care or one of the other exceptions, receive coverage or reimbursement under an EPO coverage option if you receive care from a doctor, specialist, or hospital that is not part of the Blue Cross and Blue Shield National Network.***

Some of the Blue Shield of California PPO and EPO coverage options qualify as "high deductible health plans" as defined in the federal income tax laws. They are called "HSA Compatible Plans" to identify them as being compatible with the use of a health savings account ("HSA") that provides several income tax advantages:

- **HSA Compatible Plan**. High deductible health plans—whether a PPO or an EPO—carry deductibles that are higher than those PPO and EPO coverage options that are not HSA compatible plans. These deductible amounts do not apply to certain preventive care services, but generally do apply to prescription drugs. ***For the Plan Year beginning July 1, 2022, the coverage options that are HSA Compatible Plans all have annual deductibles of at least $1,400 for self-only coverage and $2,800 for family coverage.***

Referrals for Specialty Care

An enrollee in any of the coverage options administered by Blue Shield of California may self-refer to any provider in the Blue Cross and Blue Shield National Network with one exception (as described in the next paragraph). This means that an enrollee does not need a referral from

primary care physicians to access a specialty care providers as long as the specialty provider is n Blue Cross and Blue Shield National Network—unless the exception applies.

The exception to the general rule permitting self-referrals to any provider in the Blue Cross and Blue Shield National Network applies to enrollees in an EPO that restricts referrals to providers that are part of what Blue Shield calls its "High Performance Network" or "HPN." For such enrollees, referrals for all specialty care is required from a primary care physician.

Prior Authorization Required for Certain Types of Care

Certain types of health care services require prior authorization before obtaining the services, such as a non-emergency admission to a hospital as an inpatient. You must also request prior authorization in order to receive, after an emergency, post-stabilization care from out-of-network providers.

Blue Shield maintains and updates on its website, as often as monthly, a "Prior Authorization List." This list designates medical and surgical services and select prescription drugs that require prior authorization. If prior authorization is not obtained for those services, the Reta Plan may not pay for them even if they are medically necessary and would otherwise have been covered.

Prescription Drug Benefits

Prescription drug benefits for under the Blue Shield of California coverage options are administered by CVS Caremark. The key features of the prescription drug benefits administered by CVS Caremark are as follows:

- Unless you are using the CVS Caremark Mail Service Pharmacy, you must show your Plan identification card at the pharmacy when you are requesting that a prescription be filled or refilled.

- No benefits are provided if you do not purchase the prescription drug from a pharmacy in the network operated by CVS Caremark. This national network includes pharmacies of all types, including both local and national chains such as Walgreens, Walmart, Kroger, Rite Aid, and CVS.

- You may have to pay a copayment to the participating pharmacy or, in the case of specialty drugs, a coinsurance percentage for each prescription drug you purchase. Copayments vary depending on the type of drug you purchase. If you purchase a name brand drug when there is a generic drug equivalent, you must also pay the price difference between the brand name drug and the generic drug equivalent.

- Specialty drugs must be obtained through CVS Specialty Pharmacy.

Section 8. General Description of the Benefit Program Administered by Kaiser Permanente

Geographic Conditions on Eligibility

Not all Trustors are located within a geographical area served by the health care providers in the Kaiser Permanente network. In addition, even if a Trustor is located within such a geographical area, that Trustor may have chosen not to offer the benefit program administered by Kaiser Permanente.

Kaiser Permanente Service Area Eligibility Requirement

A Reta Plan participant must live or work in the Kaiser Permanente Service Area at the time of enrollment to be covered under a coverage option administered by Kaiser Permanente. You cannot enroll or continue enrollment as a Participant or dependent if you do not live or work within the geographic areas listed or cease to do so.

The Kaiser Permanente Service Area includes parts of California, parts of Colorado, parts of Georgia, parts of Hawaii, parts of Oregon, parts of Washington, parts of Maryland, parts of Virginia, and all of Washington, D.C. The precise geographic scope of the Kaiser Permanente Service Area is described at the back of the Benefit Booklets for all of the Kaiser Permanente coverage options.

Types of Coverage Options

All Kaiser Permanente coverage options are "EPOs" or "exclusive provider organizations." Each coverage option has a specific combination of annual deductibles, copayments, coinsurance obligations, and limits on access to out-of-network providers. Some of the coverage option do not require the payment of deductibles. A Kaiser Permanente coverage option that *does* require the payment of deductibles is called a "DEPO."

- **Exclusive Provider Organization (EPO).** EPOs provide access to a network of health care providers. Of key significance, EPOs do not cover any services provided by out-of-network providers, except for emergency care and certain other circumstances. The exceptions are for emergency care, stabilization care following an emergency, and urgent care when you are physically outside the geographical area covered by the network providers. ***This means you will not receive coverage or reimbursement under an EPO coverage option if you receive care from a doctor, specialist, or hospital that is not part of the Kaiser Permanente network, unless it is for emergency care or one of the other exceptions.***

Some of the Kaiser Permanente EPOs qualify as "high deductible health plans" as defined in the federal income tax laws. They are called "HSA Compatible Plans to highlight that they are compatible with the use of a health savings account ("HSA") to obtain several income tax advantages:

- **HSA Compatible Plan**. High deductible health plans carry deductibles that are higher than those EPO and DEPO coverage options that are not HSA compatible plans. These deductible amounts do not apply to certain preventive care services, but generally do apply to prescription drugs. ***For the Plan Year beginning July 1, 2022, the coverage options that are HSA Compatible Plans all have annual deductibles of at least $1,400 for self-only coverage and $2,800 for family coverage.***

Referrals for Specialty Care

With a few excepted types of specialty care, you are required to obtain a referral from your Kaiser Permanente primary care physician prior to receiving specialty care services with a Kaiser Permanente coverage option. If you receive specialty care services for which you did not obtain a referral, the Reta Plan will ***not*** pay for or reimburse you for the charges associated with those services. See the Benefit Booklet for the coverage option in which you are enrolled for the rules on obtaining specialty care.

Prior Authorization Required for Certain Types of Care

Certain health care services require prior authorization in order for the services to be paid for by the Reta Plan. The Kaiser Permanente network physician will request prior authorization when it is required, except that you must request prior authorization in order to receive, after an emergency, covered post-stabilization care from out-of-network providers. If prior authorization is not obtained when it is required, the Reta Plan may not pay for them even if they are medically necessary and would otherwise have been covered. See the Benefit Booklet for the coverage option in which you are enrolled for the rules for prior authorization.

Prescription Drug Benefits

Prescription drug benefits under all coverage options of the Kaiser benefit program are administered by Kaiser Permanente. The key features are as follows:

- Unless you are using the Kaiser Permanente Mail Service Pharmacy, you must show your Plan identification card at the pharmacy when you are requesting that a prescription be filled or refilled.

- No benefits are provided if you do not purchase the prescription drug from a pharmacy participating in the pharmacy network operated by Kaiser Permanente. This pharmacy network includes pharmacies of all types, including both local and national chains such as Rite Aid, Walgreens, CVS, Kroger, Safeway, and Costco, plus hundreds of independent pharmacies nationwide.

- You may have to pay a copayment to the participating pharmacy or, in the case of specialty drugs, a coinsurance percentage for each prescription drug you purchase. Copayments vary depending on the type of drug you purchase. If you purchase a

name brand drug when there is a generic drug equivalent, you must also pay the price difference between the brand name drug and the generic drug equivalent.

- Specialty drugs must be obtained through Kaiser Permanente Specialty Pharmacy.

Section 9. Where To Obtain Detailed Information About Benefits Under the Reta Plan: Benefit Booklets

Benefits under the coverage options available under the Reta Plan are described only generally in this Summary Plan Description. Each coverage option covers similar services, but those services are subject to different conditions and limitations, including the choice of medical providers. Detailed information on the specific benefits vary by Benefit Program and coverage option and are set forth in the Benefit Booklet for each particular coverage option.

The Benefit Booklets for the different coverage options are available online to Participants and beneficiaries without charge from the Reta Benefit Center. They may also be requested by telephone or by email from the staff of the Reta Member Help Desk, or by writing the Administrator. You should make sure that you have or obtain copies of the Benefit Booklet for the particular coverage option in which you are enrolled, as well as this Summary Plan Description.

Each Benefit Booklet includes information concerning the following for its coverage option:

- Deductibles, copayments, and coinsurance percentages or amounts for which you are obligated to pay, as well as any limits on your "out-of-pocket" expenditures for medical and hospitalization benefits, mental health benefits, an prescription drug benefits.

- Any annual and lifetime caps and other limits on benefits.

- Extent of coverage for preventive services.

- Extent of coverage for existing and new drugs.

- Extent of coverage for medical tests, devices, and procedures.

- Provisions governing the use of network providers, composition of provider networks, and whether, and under what circumstances, coverage is provided for out-of-network services.

- General descriptions of the provider network.

- Conditions or limits on the selection of primary care providers or providers of specialty medical care.

- Conditions or limits applicable to obtaining emergency medical care.

- Provisions requiring prior authorization as a condition to obtaining a benefit or service under the Reta Plan.

- Conditions or limits on selection of facilities and primary care providers.

- Conditions or limits on selection of specialty care providers.

- Provisions excluding coverage under the Reta Plan of certain treatments and services, even if your health care provider considers them to be medically necessary.

Section 10. Your Required Contributions to the Reta Plan

Sources of Contributions

As an Employee, the costs of providing benefits under the Reta Plan are funded in part by contributions from Trustors and in part by your own contributions, usually deducted from your pay.

Your contributions toward the cost of the coverages under the Reta Plan, if any, are sometimes called "premiums." The required contributions may be increased or decreased from time to time. Information regarding the amounts of your required contributions for the coverages you select will be periodically provided by your Trustor. There ***may*** be differences in the required contributions based the benefit program you select, as well as on your employment classification and/or your rate of pay.

How You Pay Your Required Contributions or "Premiums"

Your required contributions, if any, will be deducted from your paycheck if you are an active Employee. See Section 14 of this booklet entitled "Continuation Coverage Rights Under COBRA for Employees and Dependents" for information as to how much you must pay if you elect to continue group health plan coverage available under the Reta Plan.

IMPORTANT: You Must Check Your Pay Stubs to Confirm the Deductions are Correct

You must check your pay stubs to determine whether the appropriate deductions are being made to your paycheck in order to ensure that you and any dependents are properly covered. Your failure to bring to the attention of your Trustor any errors in paycheck deductions that you could have discovered might result in you paying for coverage that you do not need and not being able to obtain a refund if too much is deducted from your paycheck. Your failure to catch an error could jeopardize the coverage of you or a family member if not enough is deducted from your paycheck.

If You Are Not Receiving a Payroll Check; Your Payment Due Date

If you are not receiving a payroll check while actively employed and enrolled in coverage, you may receive an invoice from the Reta or the COBRA Administrator at the end of each month in order to pay your required contributions. The invoice you receive will include the amount of your required contributions and where to send your payments. If you do not receive an invoice, you should contact the Reta Member Help Desk to ensure that you pay your required contributions timely. Failure to timely pay your required contributions may result in cancellation of your coverage.

Section 11. Termination of Normal Coverage

Termination of Normal Coverage of an Employee

An Employee's coverage under the Reta Plan will normally terminate on the earliest of the following dates:

- the end of the month for which the last contribution required for the Employee's coverage has been paid (including by reason of a voluntary termination of coverage); or
- the end of the month in which the Employee ceases to be eligible for coverage under the Reta Plan; or
- the end of the month in which the Employee's employment with the Trustor terminates; or
- the date the Employee enters active duty in the armed forces for a period of more than two weeks of any nation or state; or
- the end of the month following the date the Employee ceases to be actively at work for a reason other than health status, medical condition, receipt of health care, or disability, unless the cessation of work is due to a leave of absence approved by the Trustor; or
- the date the Administrator determines that the Employee is guilty of gross misconduct, such as, by way of illustration only and not of limitation, the submission of false information or the acquiescence in the submission of false information to any person in order to obtain benefits under the Reta Plan; or
- the date the Reta Plan is terminated.

In the case of an authorized non-military leave of absence, such as an authorized unpaid medical leave or sabbatical, the Trustor's policies may provide that coverage under the Reta Plan will be continued for the approved term of the unpaid leave of absence, provided that the required

contributions are continued for the Coverage Option in which the Participant is enrolled. See Section 16 of this booklet entitled "Continuation of Group Health Plan Coverage During Military Leave" for the special rules that apply to military leave.

Notwithstanding the foregoing rules, an Employee's coverage will be retroactively terminated if the Administrator determines that the Employee committed fraud or intentionally misrepresented a material fact to any person in order to obtain benefits under the Reta Plan. Retroactive termination of coverage under the Reta Plan will only occur in instances of fraud or intentional misrepresentation of a material fact. An Employee's coverage may also be retroactively terminated where the Employee retains coverage under the Reta Plan but is not eligible for coverage under the Reta Plan. In this situation, coverage will be retroactively terminated if the covered person voluntarily requests a termination of coverage retroactive to the date the Employee became ineligible for coverage under the Reta Plan.

Termination of Normal Coverage of a Dependent

Coverage for a dependent will terminate on the date such dependent ceases to meet the applicable eligibility requirements described in Section 6 of this booklet entitled "Conditions on Eligibility: Who Can Be Covered?" above, or otherwise in accordance with the rules (if any) set forth in the booklets for the particular benefit programs in which you are enrolled.

A dependent's coverage under the Reta Plan will normally terminate on the earliest of the following dates:

- the date the Participant's coverage terminates; or
- the date dependent coverage is discontinued under the Reta Plan; or
- the end of the day in which the Participant ceases to be an Employee eligible to elect dependent coverage; or
- the end of the payroll period for which the last contribution required for dependent coverage has been paid (including by reason of a voluntary termination of dependent coverage); or
- the date the Participant no longer has any dependents; or
- the date the dependent ceases to meet eligibility requirements (such as maximum age); or
- the date the Administrator determines that the dependent submitted false information or acquiesced in the submission of false information to any person in order to obtain benefits under the Reta Plan; or
- the date the Reta Plan is terminated.

Notwithstanding the foregoing rules, a dependent's coverage will be retroactively terminated if the Administrator determines that the dependent committed fraud or intentionally misrepresented a material fact to any person in order to obtain benefits under the Reta Plan. A dependent's coverage may also be retroactively terminated where the dependent retains coverage under the Reta Plan but is not eligible for coverage under the Reta Plan. In this situation, coverage will be retroactively terminated if the covered person voluntarily requests a termination of coverage retroactive to date the dependent became ineligible for coverage under the Reta Plan.

Section 12. Disqualification or Ineligibility for Benefits; Denial, Loss, or Forfeiture of Benefits

General Rules

An individual will become disqualified and ineligible for benefits under the Reta Plan if that individual fails to continue to meet the conditions on eligibility set forth in Section 4 of this booklet entitled "Eligibility Rules: Who Can Enroll?" or if coverage of that individual terminates in accordance with the rules set forth in Section 11 of this booklet entitled "Termination of Normal Coverage."

COBRA continuation coverage, in turn, is available only as set forth in Section 14 of this booklet entitled "Continuation Coverage Rights Under COBRA for Both Employees and Dependents."

Coverage during a leave of absence will be available only as set forth in Section 15 of this booklet entitled "Continuation of Group Health Plan Coverage During Leave" or Section 16 of this booklet entitled "Continuation of Group Health Plan Coverage During Military Leave," unless your Trustor provides otherwise. Nonpayment or late payment of a required contribution will also trigger a cancellation of coverage.

Fraud or Intentional Misrepresentation

Fraud or the intentional misrepresentation of a material fact on the part of a Participant or covered dependent, in order to obtain benefits under the Reta Plan will be cause for the retroactive termination of coverage under the Reta Plan. The termination of coverage shall also render the Participant or covered dependent ineligible for coverage on a prospective basis, which will in turn terminate dependent coverage. Where the Administrator has determined that the Participant or covered dependent has committed fraud or intentionally misrepresented a material fact, the Participant or covered dependent will be provided with 30 days' notice before the coverage is retroactively terminated. Once a Participant or covered dependent receives coverage under the Reta Plan, coverage will not be retroactively terminated unless the Participant or covered dependent commits fraud or intentionally misrepresents a material fact in order to obtain benefits under the Reta Plan.

Gross Misconduct; False Information

Gross misconduct on the part of a Participant or covered dependent, in the discretion of the Administrator, will be cause for the denial, loss, or forfeiture of benefits under the Reta Plan and shall also render the Participant or covered dependent ineligible for coverage, which will in turn terminate dependent coverage, if any. By way of illustration only and not of limitation, submission by a Participant or covered dependent of false information or the acquiescence in the submission of false information to any person in order to obtain benefits under the Reta Plan will constitute gross misconduct (even if such conduct might not rise to the level of fraud or intentional misrepresentation). Such submission of false information by a dependent or acquiescence by a dependent in the submission of false information will likewise trigger a denial, loss, or forfeiture of benefits under the Reta Plan with respect to that dependent and shall also render the dependent ineligible for coverage. The denial, loss, or forfeiture of benefits under the Reta Plan on the basis of gross misconduct that does not rise to the level of fraud or intentional misrepresentation will apply a prospective basis only.

Particular claims may also be denied in accordance with the terms of the various benefit programs.

Section 13. Plan Offset, Reduction, or Recovery of Benefits

Coordination of Benefits

Among the rights of the Reta Plan to offset or reduce benefits that may become payable is the right to coordinate benefits with benefits under other health coverages that are or may be available to Participants and covered dependents. Provisions governing the coordination of benefits where both the Reta Plan and another plan or coverage provide benefits for the same expense are found in the Benefit Booklets for the various benefit programs. You should refer to those Benefit Booklets for the details on the rules governing the coordination of benefits with respect to the particular benefit programs.

The Reta Plan's Right To Recover an Overpayment of Benefits

The Reta Plan reserves the right to deduct from any benefits properly payable under the Reta Plan for any noninsured benefit program the amount of any payment made as a result of an error, a misstatement contained in a claim, or with respect to a person whose medical or dental expenses were not eligible for payment or reimbursement under such benefit program. The insurance carrier for an insured benefit may also reserve a similar right, which may be found in the certificate of coverage for that benefit program.

The deduction may be taken from any benefits owed to the Participant or other beneficiary and otherwise payable with respect to any person covered by the Reta Plan. The Reta Plan may recover such amounts from any person to, for, or with respect to whom such payments were made, including without limitation any insurance company or other organization.

Any payment made by the Reta Plan shall not be construed as an admission or waiver that the expenses for which the payment was made are eligible for benefits under the Reta Plan or any particular benefit program.

The Reta Plan's Right of Subrogation and Reimbursement

In the event of an injury or illness of a Participant or other beneficiary of the Reta Plan occurring by reason of the act or omission of another person for which there exists legal liability, the Reta Plan shall have the right to reduce benefits otherwise payable by the Reta Plan or to recover benefits previously paid by the Reta Plan to the full extent of any and all recoveries or payments resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers, regardless of whether or not the recovery or payment is designated as payment for or allocable to medical expenses. The types of recoveries subject to the Reta Plan's right of subrogation include, but are not limited to, damages for pain and/or suffering, damages for loss of income, damages for medical expenses, any other compensatory damages, punitive damages, and any other monies or damages paid or to be paid by any person.

For further information on the Reta Plan's rights of subrogation and reimbursement, see the applicable Benefit Booklet for the benefit program you have selected.

Procedures That Must Be Followed Where an Injury or Illness Is Caused by Another Person (Such as an Automobile Accident)

In the event of an injury or an illness of a Participant or beneficiary of the Reta Plan occurring by reason of the act or omission of another person for which there exists legal liability, no benefits shall be payable on any claim made under the Reta Plan with respect to such injury or illness, unless certain conditions are satisfied. For a discussion of the conditions that must be satisfied, see the applicable Benefit Booklet for the benefit program you have selected.

Section 14. Continuation Coverage Rights Under COBRA for Both Employees and Dependents

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Reta Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Reta Plan is intended to comply with the continuation of group health plan coverage provisions under COBRA.

COBRA continuation coverage can become available to you and your dependents who are covered under the Reta Plan when you would otherwise lose your group health coverage. ***This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.***

The Administrator has arranged with a contract administrator to fulfill certain of the Administrator's responsibilities pertaining to COBRA continuation coverage. The contract

administrator will carry out many of the functions described in this section as being carried out by the Administrator. The contact information for the COBRA Administrator is located in the front of this booklet.

EXTENSION OF DEADLINES DUE TO NATIONAL EMERGENCY

The National Emergency declaration concerning the COVID-19 pandemic has resulted in an extension of several of the otherwise applicable deadlines stated in this booklet pertaining to electing COBRA continuation coverage. If you think you have missed a deadline stated in this booklet, you should telephone the Reta Member Help Desk at 877-303-7382 to find out if the extension of deadlines allows you more time than is stated in this Summary Plan Description.

The following COBRA timeframes set forth in this Section 14 have been extended due to the National Emergency:

- ***The 60-day election period for electing COBRA continuation coverage;***
- ***The 45-day initial COBRA premium deadline;***
- ***The 30-day grace period for subsequent monthly COBRA premiums;***
- ***The 14-day period, following notice of an event, that plans have to provide qualified beneficiaries with an election notice; and***
- ***The 60-day period that qualified beneficiaries have to provide notice to the employer of a qualifying event or disability determination.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Reta Plan because of a qualifying event. Depending on the type of qualifying event, Employees, spouses of Employees, dependent children of Employees, and a child who is born to or placed for adoption with an Employee during a period of continuation coverage may be qualified beneficiaries. Under the Reta Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

In general, an individual (other than a child who is born to or placed for adoption with an Employee during a period of continuation coverage) who is not covered under the group health plan coverage of the Reta Plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event. The reason for the individual's lack of actual

coverage (such as the individual's having declined participation in the Reta Plan or failed to satisfy the Reta Plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered group health plan coverage under the Reta Plan under circumstances in which the denial of or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the coverage that was wrongfully denied or not offered, and thus could be eligible for COBRA continuation coverage.

COBRA continuation coverage is the same coverage that the Reta Plan gives to other Participants or beneficiaries under the Reta Plan who are not receiving continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights and obligations under the Reta Plan as other Participants or beneficiaries covered under the Reta Plan, including, without limitation, the provisions governing special enrollment rights, maximum benefit limitations, and any managed care limitations or requirements.

Do Not Reject COBRA Continuation Coverage Without Considering These Important Factors

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. For example, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event that resulted in a loss of coverage under the Reta Plan. You will also have the same special enrollment right at the end of COBRA continuation coverage if you maintain COBRA continuation coverage for the maximum time available to you.

What Qualifying Events Might Trigger COBRA Continuation Coverage?

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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

How Close in Time Must the Qualifying Event Be to the Loss of Coverage?

For purposes of determining whether a qualifying event has occurred, a loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum COBRA continuation coverage period associated with that event. However, if neither the Employee nor another qualified beneficiary loses coverage before what would be the end of such maximum coverage period, then the event is not a qualifying event.

If a potential qualified beneficiary's coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. For example, if an Employee drops coverage for his or her spouse several months early in anticipation of a divorce or legal separation, then, upon receiving notice of the divorce or legal separation in a timely manner, the Reta Plan will make COBRA continuation coverage available to the spouse, effective on the date of the divorce or legal separation (but not for any period before the date of divorce or legal separation).

When Will Notice of a Qualifying Event Be Given Automatically to the Administrator?

The Reta Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or the death of the Employee, the Administrator will be deemed to have been notified automatically. Because the Reta Plan provides retiree health coverage for certain eligible individuals, upon the commencement of a proceeding in bankruptcy with respect to the Trustor, that circumstance will be a qualifying event for which the Administrator will be deemed to have been notified automatically.

When Must You Notify the Administrator of a Qualifying Event or Other Event that May Affect COBRA Continuation Coverage?

When certain events occur that may trigger, extend, or otherwise affect the COBRA continuation coverage of you, your spouse, or your children, you are under an obligation to give written notice to the Administrator of the event. ***IMPORTANT: Failure to do so may trigger a loss of COBRA continuation coverage for you, your spouse, or your child or children.*** Either you, your spouse, your child, or a representative acting on behalf of you, your spouse, or child may provide the notice. The events which trigger a responsibility on your part to notify the Administrator in writing are as follows:

Divorce or Legal Separation. You must notify the Administrator in writing if you become divorced or legally separated from your spouse. You must include with your written notice your name, address, contact telephone number, and a copy of the divorce decree or court order of separation. You must provide the written notice within 60 days of the date on which the divorce or legal separation occurs or the date on which your spouse loses (or would lose) coverage under the Reta Plan as a result of the divorce or legal separation, whichever is later.

Child Ceasing To Qualify for Coverage. You must notify the Administrator in writing if one or more of your children stops being eligible under the Reta Plan as a "dependent child." For example, if your non-disabled child attains age 26, your child no longer qualifies for coverage under the Reta Plan as a "dependent child." You must include with your written notice your name, address, contact telephone number, the name of your child, and an explanation of how your child ceased to be an eligible dependent. You must provide the written notice within 60 days of the date on which your child ceases to qualify for coverage under the Reta Plan or the date on which your child loses (or would lose) coverage under the Reta Plan, whichever is later.

Second Qualifying Event. You must notify the Administrator in writing if your family experiences a second qualifying event, while receiving 18 months of COBRA continuation coverage, that would extend the maximum period of continuation coverage from 18 (or 29) months to 36 months. You must include with your written notice your name, address, contact telephone number, and a description of the second qualifying event and precisely when it occurred. You must provide the written notice within 60 days of the date on which the second qualifying event occurs or the date on which you or another qualifying beneficiary loses (or would lose) coverage at the end of the initial maximum period of COBRA continuation coverage, whichever is later.

Determination of Disability by Social Security Administration. You must notify the Administrator in writing if a qualified beneficiary has been determined by the Social Security Administration to be disabled within the first 60 days of COBRA continuation coverage (after the qualified beneficiary has become entitled to a maximum of 18 months of COBRA continuation coverage). You must include with your written notice your name, address, contact telephone number, the name of the disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 60 days of (i) the date of the disability determination by the Social Security Administration, (ii) the date on which the qualifying event occurred, or (iii) the date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event, whichever is later.

Determination of End of Disability by Social Security Administration. You must notify the Administrator in writing if Social Security Administration determines that a qualified beneficiary is no longer disabled. You are required to notify the Administrator only if notice of disability within the first 60 days of COBRA continuation coverage was given to the Administrator in order to obtain the extension of COBRA continuation coverage by reason of disability. You must include with your written notice your name, address, contact telephone number, the name of the formerly disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

When Does COBRA Continuation Coverage Start?

Once the Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

When Does COBRA Continuation Coverage Normally Last Up to 18 Months? When Does It Last Longer?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours, and the Employee became enrolled in Medicare (under Part A, Part B, or both) less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts for up to 36 months after the date of Medicare enrollment. For example, if a covered Employee enrolls in Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment, the reduction of the Employee's hours of employment, or the dependent child of an Early Retiree reaching age 26, COBRA continuation coverage lasts for up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended: (i) a qualified beneficiary becomes disabled; or (ii) a second qualifying event occurs. These two methods for continuing coverage are discussed below.

When Does a Disability Extend Normal COBRA Coverage Up to a Maximum of 29 Months?

If you or anyone in your family covered under the Reta Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA continuation coverage period, the COBRA continuation coverage period may be extended by 11 months to a total maximum of 29 months if certain conditions are satisfied. The conditions that must be satisfied are as follows:

- The qualifying event must be your termination of employment or reduction in hours;

- The qualified beneficiary (who may be you or your spouse or your dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of the COBRA continuation coverage period; and

- The qualified beneficiary must notify the Administrator of the disability determination within 60 days after the date of the determination and before the end of the original 18-month period that applies to the qualifying event. ***This notice should be sent to the COBRA Administrator.***

If the foregoing conditions are satisfied, the disability extension applies to all qualified beneficiaries (all family members who had coverage) with respect to the qualifying event, not only to the disabled qualified beneficiary.

If the qualified beneficiary (who may be you or your spouse or your dependent child) is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days of the Social Security Administration's determination.

When Does a Second Qualifying Event Extend Normal COBRA Continuation Coverage Up to a Maximum of 36 Months?

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former Employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Reta Plan as a dependent child.

When May COBRA Continuation Coverage Be Cut Off Early?

The right to continue group health plan coverage that has been elected for a qualified beneficiary will end before the last day of the maximum continuation coverage period upon the earliest of the following dates:

- The first day for which timely payment for continuation coverage is not made to the Reta Plan with respect to the qualified beneficiary, subject to any grace period allowance as described below.

- The date on which the Trustor ceases to provide any group health plan coverage to any employee.

- The date, after the date of election of continuation coverage, upon which the qualified beneficiary first becomes actually covered under any other group health plan (as an employee or otherwise).

- The date, after the date of election of continuation coverage, the qualified beneficiary first becomes entitled to Medicare benefits, which date is the effective date of enrollment in Medicare (Part A or Part B or both). This rule cutting off coverage early does not apply to a qualified beneficiary who is entitled to the special period of coverage that applies in the event of the bankruptcy (or similar proceeding) of the Trustor.

- The date the Reta Plan terminates for cause the coverage of a qualified beneficiary on the same basis that the Reta Plan terminates for cause the coverage of similarly situated Plan beneficiaries who have not elected continuation coverage (such as filing fraudulent claims).

How Do You (or Another Qualified Beneficiary) Elect COBRA Continuation Coverage?

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. For example, both the Employee and the Employee's spouse may elect COBRA continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election form provided by the Administrator. Failure to do so will result in loss of the right to elect continuation coverage under the Reta Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the Reta Plan (including both Trustor and Employee contributions) for coverage of a similarly situated Participant or beneficiary who is not receiving continuation

coverage, plus any additional amounts that are permitted by COBRA continuation coverage. Required contributions for qualified beneficiaries electing continuation coverage may be increased by the Trustor from one year to the next.

When and How Must Your First Payment for COBRA Continuation Coverage Be Made?

If you elect COBRA continuation coverage, you do not have to send any payment for COBRA continuation coverage with the election form provided by the Administrator. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the election notice is post-marked with a United States postmark, if mailed.) ***If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Reta Plan.***

Your first payment must cover the cost of continuation coverage from the time your coverage under the Reta Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator (see the beginning of this booklet) to confirm the correct amount of your first payment. Your first payment for continuation coverage should be sent to the COBRA Administrator.

When and How Must Your Subsequent Payments for COBRA Continuation Coverage Be Made?

After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. Under the Reta Plan, these periodic payments for COBRA continuation coverage are due on the first day of the month for which the contribution is made. If you make a periodic payment on or before its due date, your coverage under the Reta Plan will continue for that coverage period without any break. The Reta Plan will not send periodic notices of payments due for these coverage periods. Periodic payments for continuation coverage should be sent to the COBRA Administrator.

Is There Any Grace Period for Your Subsequent Payments for COBRA Continuation Coverage?

Although periodic payments are due on the first day of the month for which you are requesting coverage, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Payment is considered made on the date it is sent to the Reta Plan or the Trustor as evidenced by the United States postmark date, not a private post meter date. See Section 10 of this booklet entitled "Your Required Contributions to the Reta Plan" for information on where to send your contributions if you have elected COBRA continuation coverage and you have not received specific instructions as to where to send your contributions.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Reta Plan.

To Whom Should You Direct Questions?

Questions concerning the Reta Plan or your COBRA continuation coverage rights should be addressed to the Administrator or the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website at http://www.dol.gov/ebsa.

Keep the Reta Plan Informed of Address Changes

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

Section 15. Continuation of Group Health Plan Coverage During FMLA Leave

In General

Normally, you have no right to continue any coverage under the Reta Plan while you are on a leave of absence unless you have exercised your rights described in Section 14 of this booklet entitled "Continuation Coverage Rights Under COBRA (for Employees and Dependents)." An exception to this rule permits continuation of group health plan coverage during leave guaranteed under the Family and Medical Leave Act of 1993 (FMLA) as described in this section.

If your Trustor is subject to the FMLA, continuation of group health plan coverage under the Reta Plan and reinstatement of coverage is available to Employees and their covered eligible dependents under certain specified conditions. A Participant who takes a leave of absence under the FMLA is entitled to continue group health plan coverage under the Reta Plan for himself or herself and his or her covered eligible dependents to the same extent as if the Participant had been actively at work during the entire leave period permitted by FMLA, subject to the terms and conditions set forth below.

Cancellation of Coverage If Payments Are Not Made During FMLA Leave

Required payments for the coverage for the Participant (and his or her covered eligible dependents), if any, must be received on or before the date payment would be due if made by payroll deduction. An obligation to maintain coverage under the Reta Plan during FMLA leave

ceases if the Participant's contribution is more than 30 days late. As a precondition to dropping coverage during FMLA leave, the Trustor or Administrator must provide written notice to the Participant that the payment has not been received. The notice shall be mailed to the Participant at least 15 days before coverage is to cease, advising that coverage will be dropped on a specified date at least 15 days after the date of the notice unless payment of the contribution has been received by that date. Coverage for the Participant and his or her eligible dependents shall cease at the end of the 30-day grace period, where the required 15-day notice has been provided.

The Trustor may recover the Participant's required contribution payments missed by the Participant for any FMLA leave period during which the Trustor maintains coverage under the Reta Plan by paying the Participant's contribution after the payment is missed.

The Trustors have the right, as permitted and as limited by the FMLA and the regulations thereon, to recover its share of the applicable cost of coverage during a period of an unpaid FMLA leave for a Participant if the Participant fails to return to work after Participant's FMLA leave entitlement has been exhausted or expired.

Reinstatement of Coverage Upon Return from FMLA Leave

If the Participant declines coverage during the leave or if the Participant's coverage is terminated as result of his failure to pay any required contributions, the Participant shall, upon return from the leave permitted by the FMLA, be entitled to be reinstated to coverage under the Reta Plan on the same terms as prior to taking leave, without any waiting period or physical examination, but subject to the Trustor's eligibility rules.

When Does COBRA Continuation Coverage Start If You Do Not Return from FMLA Leave?

If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee and their covered eligible dependents will be entitled to elect COBRA continuation coverage if (i) they were covered under the Reta Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (ii) they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the FMLA leave. COBRA continuation coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA continuation coverage qualifying events of termination of employment and reduction of hours.

Notwithstanding the foregoing, your Trustor's leave policy may permit an authorized extension of leave following FMLA leave during which coverage is not lost if the Participant continues to make the required contributions during the authorized leave. In that event, COBRA continuation coverage elected in these circumstances will begin on the day coverage is lost either during or at the end of the authorized non-FMLA leave.

Special Limitations Applicable to Key Employees

A "Key Employee" is a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid 10% of all the Employees employed by the Trustor within 75 miles of a particular Trustor work site.

If a Participant who is a "Key Employee" does not return from leave when notified by the Trustor that substantial or grievous economic injury to the Trustor will result from his or her reinstatement, the Key Employee's entitlement to group health plan benefits continues unless and until the Participant advises the Trustor that he or she does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

Except as required by COBRA, the Trustor's obligation to maintain group health plan coverage under the Reta Plan for a Participant who is a Key Employee ceases if and when any one of the following events occur:

- The employment relationship would have terminated if the Participant had not taken FMLA leave (e.g., if the Participant's position is eliminated as part of nondiscriminatory reduction in force and the Participant would not have been transferred to another position).

- The Participant informs the Trustor of his or her intent not to return from leave (including before starting leave if the Trustor is so informed before the leave starts).

- The Participant fails to return from leave or continues on leave after exhausting his or her FMLA leave entitlement in the applicable 12-month period.

Section 16. Continuation of Group Health Plan Coverage During Military Leave

This section describes continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Continuation of group health plan coverage is available to Employees who take U.S. military leave and their covered eligible dependents under certain specified conditions. A Participant must give the Administrator written notice within 60 days of his or her absence from employment for military service and a desire to elect continuation of group health plan coverage under USERRA.

The requirement of written notice within 60 days, however, does not apply if that type of notice is precluded by military necessity or if the giving of that type of notice is impossible or unreasonable under the circumstances. In that event, the notice may be as late as is reasonable under the circumstances. Similarly, the notice may be oral if written notice would be unreasonable under the circumstances.

Any extension of benefits period provided pursuant to this section will not postpone the starting date for measurement of the maximum period available for continuation of benefits

pursuant to Section 14 of this booklet entitled "Continuation Coverage Rights Under COBRA (for Employees and Dependents)." In other words, COBRA continuation coverage and USERRA coverage will run concurrently because the events giving rise to the respective rights occur at the same time.

What Group Health Plan Coverage Will Be Provided?

A Participant may elect to continue group health plan coverage for himself and his covered eligible dependents if coverage would otherwise cease under the Reta Plan due to the Participant's absence from employment by reason of his or her service in the uniformed services. To elect to continue group health plan coverage under USERRA, a Participant should complete the appropriate election and pay the applicable premium, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Benefits under the Reta Plan for Participants under an election for military leave continuation coverage shall be the same coverage as provided to all other Participants. If benefits under the Reta Plan are increased, decreased, or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Participants. An Employee may not, however, initiate new coverage at the beginning of a period of service if the Employee did not previously have such coverage.

How Much Do You Have To Pay To Continue Your Health Plan Coverage?

A Participant who elects to continue group health plan coverage under USERRA may be required to pay not more than 102 percent of the full premium under the Reta Plan (the same rate as with COBRA continuation coverage). Notwithstanding the foregoing, in the event an Employee performs services in the uniformed services for less than 31 days, such person will not be required to pay more than the Employee share, if any, for such coverage.

In addition, the Trustor's leave policy may extend the period during which an Employee on military leave will not be required to pay more than the Employee share for continued coverage.

Duration of USERRA Coverage

The maximum period of coverage available to all Participants under the provisions of this section shall be the lesser of:

- the 24-month period beginning on the date on which the Employee's absence for the purpose of performing service begins; or

- the period beginning on the date on which the Employee's absence for the purpose of performing service begins, and ending on the date on which the Employee fails

to return from service or apply for a position of employment as provided under section 4312(e) of USERRA.

In the event a Participant fails to pay the required premiums, coverage will be cancelled. In addition, coverage will be terminated if the Participant loses his or her rights under USERRA as a result of certain types of undesirable conduct, such as court-martial and dishonorable discharge.

If Coverage Was Terminated During Military Service, Must Coverage Be Reinstated Upon Reemployment?

If group health plan coverage for an Employee or a dependent was terminated by reason of the Employee's service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of the Employee's coverage upon reemployment if an exclusion or waiting period would not have been imposed had the Employee's coverage not been terminated by reason of such service.

A particular benefit program under the Reta Plan may impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs or his or her representative to have been incurred in, or aggravated during, performance of service in the uniformed services. Other coverage, for injuries or illnesses that are not service-related (or for an Employee's eligible dependents, if the Employee has dependent coverage), must be reinstated.

A Trustor will reinstate an Employee's group health plan coverage upon request at reemployment. An Trustor may not delay reinstatement of group health plan coverage until a date that is later than the date of the Employee's reemployment.

Section 17. Information About Filing Claims for Benefits and Appealing Denied Claims

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EXTENSION OF DEADLINES DUE TO NATIONAL EMERGENCY: The National Emergency declaration concerning the COVID-19 pandemic has resulted in an extension of several of the otherwise applicable deadlines stated in this booklet pertaining to filing claims for benefits and appeals of denied claims. If you think you have missed a deadline stated in this booklet, you should telephone the Reta Member Help Desk at 877-303-7382 to find out if the extension of deadlines allows you more time than is stated in this Summary Plan Description.

Your General Rights To File Claims for Benefits

You may make any claim for benefits on your own behalf or through a representative duly authorized by you to act on your behalf. A "claim for benefits" is a request for a Plan benefit or benefits made by you or by your representative that complies with the procedures for making benefit claims. A claim for benefits also includes a request for a determination as to whether a proposed treatment or service is covered or for preauthorization or approval of a particular treatment or service.

The claims procedures will not be administered in a way that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, no payment of any fee or costs will be imposed for making a claim for benefits.

If you make a claim for an eligibility reason (such as your Trustor not treating you as a full-time Employee and you believe that you are full-time or did not timely notify the Administrator of a new dependent), see Section 18 entitled "Information About Appealing a Denial of Eligibility."

You should refer to the separate Benefit Booklets for the coverage option in which you are enrolled for the specific procedures governing the filing of benefit claims and the time limits for filing claims.

Your Right to Appeal Denied Claims

You have the right to contest a denial of a claim or other adverse benefit determination on your own behalf or through a representative authorized by you to act on your behalf. An "adverse benefit determination" means any one of the following actions either before or after you receive treatment:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Reta Plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review directed at cost containment; and
- a failure to cover an item of service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Reta Plan's procedures regarding denied claims for benefits will not be administered in any way that requires a claimant to submit an adverse benefit determination to arbitration or to file more than one appeal of an adverse benefit decision prior to bringing a lawsuit to contest an adverse benefit determination. The procedures will not be administered in a way that unduly inhibits or hampers the appeal of an adverse benefit determination. For example, there is no payment of any fee or costs for appealing an adverse benefit determination.

You should refer to the separate Benefit Booklet for the coverage option in which you are enrolled for the specific procedures governing appeals and the time limits for appealing denied claims.

Section 18. Information About Appealing a Denial of Eligibility

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EXTENSION OF DEADLINES DUE TO NATIONAL EMERGENCY: The National Emergency declaration concerning the COVID-19 pandemic has resulted in an extension of several of the otherwise applicable deadlines stated in this booklet pertaining to filing claims for eligibility and appeals of denied claims. If you think you have missed a deadline stated in this booklet, you should telephone the Reta Member Help Desk at 877-303-7382 to find out if the extension of deadlines allows you more time than is stated in this Summary Plan Description.

Appealing an Eligibility Denial

If you have a denied claim for benefits or eligibility and the basis of decision is that you or your dependent were not eligible or not covered by the Reta Plan at the time of claim, you may submit an eligibility appeal to the Administrator:

Reta Trust
2121 North California Boulevard, Suite 350
Walnut Creek, CA 94596
877-303-7382

The Administrator has 15 days to review and respond to your eligibility appeal. This time period may be extended, however, for an additional 15 days for matters beyond the control of the Administrator, including in cases where an eligibility appeal is incomplete. The Administrator will provide written notice of any extension.

When an eligibility appeal is incomplete, the notice will also specifically describe what documentation is missing. The Administrator will allow you 45 days from receipt of this notice in which to provide the specified information. This effectively suspends the time for a decision on your eligibility appeal until the specified information is provided. If the missing documentation is not received by the Administrator within this time frame, your eligibility appeal request will be closed.

If your eligibility appeal is denied, notification will be sent to you and will include the following:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based; and

- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to bring a legal action (where applicable) with respect to any adverse determination after appeal of your claim.

Your Right to Request a Review of a Denied Eligibility Appeal

If your eligibility appeal is denied, you (or your authorized representative) may request review of the denial upon written notification to the Administrator within 180 days of the date that your eligibility appeal was denied. If you do not respond to request further review within 180 days, you will lose the right to challenge the decision and may also lose your right to file suit in a court of law.

Your request for a review should include a written statement of the reasons why you believe your eligibility appeal should be approved. It should include any new and/or additional facts and/or documents that you feel support your eligibility appeals. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your eligibility appeal.

Your request for a review of the denial will be reviewed and decided by the Administrator or other entity designated in the Reta Plan in a reasonable time not later than 60 days after the Administrator receives your request for review. The Administrator may, in its discretion, hold a hearing on the denied eligibility appeal. If the decision on review is an adverse benefit determination and affirms the initial denial, you will be furnished with a notice of the review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring a legal action (where applicable).

Section 19. Your Right to File a Lawsuit To Contest an Adverse Benefit Determination

General Rules

You have the right to bring a lawsuit to contest in court an adverse benefit determination after your initial claim for benefits has been denied and your appeal of the denial has been subsequently reviewed. The basis in Federal law for such a lawsuit is section 502(a) of the Employee Retirement Income Security Act of 1974. You may sue in either state or federal court. If you originally commence your lawsuit in state court, however, the case may be transferred to federal court.

Lawsuits to challenge an adverse benefit determination may be filed against the Reta Plan in its own name.

You Must Exhaust Administrative Remedies Before Filing a Lawsuit

Before filing a lawsuit, you must first use the Reta Plan's internal claims and claims review (appeal) procedures. If you do not do so and then file a lawsuit to contest an adverse determination of benefits, your lawsuit will not be heard by the court, unless the court finds reason to excuse your failure to exhaust the administrative procedures available to you. You do not need to pursue the process of a voluntary appeal to the Administrator, although that step might be fruitful.

Your One-Year Deadline to File a Lawsuit

ANY LAWSUIT TO CONTEST AN ADVERSE BENEFIT DETERMINATION MUST BE COMMENCED NO LATER THAN ONE YEAR AFTER THE DATE OF THE FINAL ADVERSE DETERMINATION ON THE CLAIM OR OTHER REQUEST FOR BENEFITS. If an appeal of a denial of a claim or other request for benefits is denied as untimely, the latest decision on the merits of the underlying claim or benefit request is the final adverse determination for this purpose.

If you make a voluntary appeal for a review of adverse benefit determination to the Administrator, then the one-year deadline to file a lawsuit, if it has not already expired, is suspended during the time the voluntary appeal is pending, but not less than 90 days.

Section 20. Very Important Notices of Special Legal Rights

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What Is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your Plan agreed to pay and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You Are Protected From Balance Billing for Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your Plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

You Are Protected From Balance Billing for
Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers ***cannot*** balance bill you and may ***not*** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers *cannot* balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You may choose a provider or facility in the Reta Plan's network for the benefit program.

When Balance Billing Is Not Allowed, You Also Have Several Protections

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your Plan will pay out-of-network providers and facilities directly.

- The Reta Plan generally will:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact the Federal government's No Surprises Help Desk at 1-800-985-3059.

Visit the website: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under Federal law under the No Surprises Act.

Your Rights to Minimum Hospital Stays After Childbirth

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights to Breast Reconstruction and Related Services After a Mastectomy

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Coverage Option in which you are enrolled. If you would like more information on WHCRA benefits, call the appropriate Claims Administrator at the telephone number listed at the front of this booklet.

Procedures for Qualified Medical Child Support Orders

This section pertains to a court or a legally enforceable administrative order that provides for group health plan coverage to a child of a Participant as a form of child support or in the nature of child support.

The Reta Plan will comply with the terms of a Qualified Medical Child Support Order (MISO), directing the Reta Plan to provide benefits to one or more alternate recipients, pursuant to the procedures set forth below:

- An order which purports to be a QMCSO must be served on the Administrator.

- The Administrator shall, within 20 days of its receipt of the order, notify the Participant and each dependent covered by the order of the receipt of the order and the Reta Plan's procedures for deciding whether a medical child support order is a QMCSO.

- Within 60 days after receipt of the order, the Reta Plan shall make a determination as to whether or not such order is a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

  (a) a clause which creates or recognizes the existence of a dependent's right to receive benefits under the Reta Plan;

  (b) the name and last known mailing address of the Employee with respect to whom the order is issued and the name and address of each dependent covered by the order;

  (c) a reasonable description of the type of coverage to be provided by the Reta Plan to each dependent or the manner in which such type of coverage is to be determined;

  (d) a clause which specifies that the order applies to the Reta Plan, as well as the time period to which the order applies;

  (e) a clause which states that the order does not require the Reta Plan to provide any type or form of benefit not otherwise provided under the Reta Plan, except as allowed by law; and

  (f) An appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 meeting the requirements of items (d) and (e) above will be deemed to be a QMCSO.

- An order which, in the judgment of the Administrator, does not meet the requirements of a QMCSO shall be returned to the attorney or other person who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with these procedures.

- The Administrator shall notify all parties involved, including a designated representative of the covered dependent, of the Administrator's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Reta Plan pursuant to a QMCSO may be made to the covered dependent or the covered dependent's custodial parent.

Coordination with Medicaid Eligibility

Payment for benefits with respect to a Participant or beneficiary (an eligible dependent) under the Reta Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or beneficiary as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912(a) (1) (a) of such Act, as in effect August 10, 1993.

In enrolling or in determining or making any payments for benefits of an individual as a Participant or beneficiary, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Reta Plan has a legal liability to make payment for the items or services constituting such assistance, payment for benefits under the Reta Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

Your Rights to Select Primary Care, Pediatric, and OB/GYN Providers—Patient Protections

If the benefit program in which you are enrolled allows or requires the designation of a primary care provider, you have some specific rights. You have the right to designate any primary care provider who participates in the benefit program's provider network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

If the Claims Administrator designates a primary care provider automatically, you may select another one. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the telephone number listed in the front section of this booklet.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in benefit program network 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 Claims Administrator at the telephone number listed in the front section of this booklet.

Maintenance of May 1, 1993 Coverage for Certain Pediatric Vaccines

Federal law prohibits a group health plan from reducing its coverage of the costs of pediatric vaccines below the coverage provided by the group health plan as of May 1, 1993. For this purpose, "pediatric vaccines" are defined in section 1928(h)(6) of the Social Security Act as amended by section 13830 of the Omnibus Budget Reconciliation Act of 1993.

Interference with Your Rights; Discrimination or Retaliation For Exercising Your Rights

Federal law provides that no one, including your Trustor, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Reta Plan or for exercising your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

If you believe this federal law has been violated, you should utilize the Reta Plan's claim and appeals procedures described in general terms earlier in this booklet. The Administrator is authorized to hear claims for these types of violations of the law. If you do not use the Reta Plan's claims and appeals provisions, and if you file a lawsuit seeking remedies for interference with your rights or discrimination or retaliation for exercising your rights, your claim may not be heard by the court because you failed to utilize the Reta Plan's internal claims and appeals procedures.

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administrator's office and at other specified locations, such as work sites, all documents governing the Reta Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Reta Plan with the U.S. Department of Labor.

- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Reta Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied, 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 change, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Reta 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 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. ***Before filing suit, however, you must exhaust the administrative procedures available under the Reta Plan to challenge a denial of benefits, unless the court finds reason to excuse your failure to exhaust the administrative procedures.***

In addition, if you disagree with the Reta Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Reta 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.

ANY LAWSUIT TO CONTEST AN ADVERSE BENEFIT DETERMINATION MUST BE COMMENCED NO LATER THAN TWO YEARS AFTER THE DATE THE RELEVANT EXPENSE WAS INCURRED OR, IF NO EXPENSE WAS INCURRED, WITHIN ONE YEAR OF THE INITIAL ADVERSE DETERMINATION.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.