WRNS STUDIO
HEALTH & WELFARE PLAN

Summary Plan Description

January 1, 2018

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PLAN INFORMATION

This document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions ("Benefit Documents"), constitutes this Plan's Summary Plan Description ("SPD") pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA").

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan's benefits ("Component Plans") as of January 1, 2018, which may change from time to time. You should keep this SPD with the Benefits Documents provided to you upon enrollment in each benefit plan. You also should share this SPD with any family members you have elected to cover under the Plan.

Plan Name:	WRNS Studio Health & Welfare Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31 of the same calendar year
Plan Number:	501
Effective Date of this SPD:	January 1, 2018
Original Effective Date of Plan:	June 1, 2005
Funding Method:	Funded through fully-insured contracts and self-funded arrangements
Source of Contributions:	From WRNS Studio's general assets and Employee contributions, when required by WRNS Studio in its sole discretion
Plan Sponsor and Plan Administrator:	WRNS Studio 501 Second Street, 4th Floor, Suite 402 San Francisco, CA 94107 415-489-2224
Plan Sponsor's Employer Identification Number:	45-5569176
Agent for Service of Legal Process:	WRNS Studio 501 Second Street, 4th Floor, Suite 402 San Francisco, CA 94107 415-489-2224
Claims Administrators:	See Appendix B or the Benefit Documents associated with each Component Plan

For additional information regarding the Plan, contact Melinda Rosenberg at 415-489-2224 or refer to the Benefits Documents for the applicable Component Plan. Copies of the documents are available from WRNS Studio on request.

INTRODUCTION

Establishment and Purpose

WRNS Studio ("WRNS Studio") maintains the WRNS Studio Health & Welfare Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between WRNS Studio and insurance companies or service providers ("issuers"), as well as through self-funded plans funded by the general assets of WRNS Studio.

The benefit plans offered under this Plan and their issuers or contract administrators are listed in Appendix A. Detailed information on the benefits listed in Appendix A may be found in the Benefit Documents.

If the terms of this SPD conflict with the terms of the related Benefit Documents, the terms of the related Benefit Documents will control, unless superseded by applicable law.

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

Specific Plan Information

Eligibility Rules. Please refer to Appendix C of this SPD to determine your eligibility for participating in each benefit program. WRNS Studio's benefits guide or the specific Benefit Documents will also define eligible dependents (if applicable) and the terms under which you may participate (including the definition of an eligible employee and a description of any waiting period, which may precede the date your coverage begins).

Benefits Provided. Each Component Plan's Benefit Documents will contain a complete description of the benefits available and any limitations or exclusions applicable to those benefits.

Contributions. WRNS Studio, at its discretion, may require employee contributions as a condition of participation in any benefit plan. Employee contributions may be made on an after-tax basis or on a pre-tax basis through a cafeteria plan component benefit program under the Plan.

Initial Enrollment. If you are eligible to participate in the Plan, you can become a participant by completing an enrollment form or enrolling online, if applicable. If you do not enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

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

Changing Elections. Federal law generally requires that an election made under the Plan remain in effect without modification for the entire Plan Year for which the election is made. You may, however, be able to revoke or change an election on account of, and consistent with one of qualifying election change events adopted by WRNS Studio, as permitted by federal law. See below for additional details on special open enrollment rights under HIPAA.

Any election made on an after-tax basis may be changed in accordance with WRNS Studio's policy and any specific Plan limitation.

Restitution to the Plan. The Plan has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances and with respect to certain component benefit programs. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing

documents provide additional information about the Plan's recovery, subrogation, and reimbursement rights.

Cessation of Participation. Unless otherwise stated in the Benefit Documents your coverage will cease upon the earliest of the following:

- the date your eligible class is eliminated;
- the date you cease to be a member of an eligible class;
- the date you cease to pay any required contributions toward the cost of the Plan; or,
- the date the Plan is terminated.

Discrimination Based on Health-Related Factors Prohibited. HIPAA prohibits health plans from discriminating against any Participant or Dependent in terms of eligibility to participate in the Plan based on a health-related factor. The Plan may limit or exclude benefits that are experimental or are not medically necessary, or require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals.

Special Open Enrollment Rights for Certain Individuals under HIPAA

HIPAA requires group health plan to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries.

Coverage will generally begin on the first day of the calendar month following the timely enrollment request. However, if the special enrollment event is birth or adoption or placement for adoption, if timely enrolled, coverage for such newborn or adopted children will begin as of the date of birth, adoption, or placement for adoption.

Any requests for special enrollment or to obtain more information should be directed to:

WRNS Studio
Attn: Melinda Rosenberg
501 Second Street, 4th Floor, Suite 402
San Francisco, CA 94107
415-489-2224

If you otherwise decline to enroll, you may be required to wait until the group's next open enrollment to do so. You also may be subject to additional limitations on the coverage available at that time.

Loss of Eligibility for Group Health Coverage or Health Insurance Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in one of the health care options offered by WRNS Studio, provided that you request enrollment within 31 days after your other coverage ends or any company contributions for such coverage have terminated. If the other coverage is COBRA coverage, the entire COBRA continuation coverage period must be exhausted before enrolling in this Plan.

Furthermore, you and your dependents who are eligible for coverage but not enrolled, may be eligible to enroll for coverage under this Plan within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan ("CHIP") plan.

Acquisition of a New Spouse or Dependent

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Becoming Eligible for State Premium Assistance Subsidy

If you are eligible for health coverage under this Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in Appendix D, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office using the information contained in Appendix D, call 1-877-543-7669, or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are not eligible for Medicaid, CHIP, or a state premium assistance program you may be able to buy individual insurance coverage through a Health Insurance Marketplace (such as Covered California). For more information, visit www.healthcare.gov.

Leave of Absence

WRNS Studio may continue your coverage under the Plan during certain periods of absence, such as absence by reason of sickness, disability, or other authorized leave of absence (including military leaves), in accordance with its employee handbook and/or personnel policies and practices and to the extent prescribed by law. Please refer to WRNS Studio's leave documentation for a description of the different types of leaves of absence, how long benefits are continued during a leave of absence, what employee contributions are required during the leave and how those contributions are made.

Family and Medical Leave Act

Notwithstanding the rule regarding termination of participation or any other provision to the contrary in this Plan, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 ("FMLA"), the following rules will apply.

- Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), WRNS Studio will continue to maintain your health benefits on the same terms and conditions as though you were still an active employee. WRNS Studio will require you to continue to make any normally required contributions for your health benefits. If you do not make such payments, or do not make them in a timely manner, your health coverage may cease, as provided by FMLA.
- Except as otherwise provided by FMLA (including if your participation is terminated for the non-payment of any required contributions), your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time.
- Except as otherwise provided in FMLA, if you fail to return to work after the FMLA leave, you may be required to reimburse WRNS Studio for the cost of the coverage WRNS Studio provided you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on).

Eligible employees generally may take up to 12 work weeks' leave during a 12-month period for the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of their own serious health condition, or for a "qualifying exigency" related to a spouse, child, or parent on or called to Armed Forces active duty in a foreign country.

Up to 26 work weeks of "military caregiver leave" during a 12-month period may be available to an eligible employee who cares for a covered servicemember with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the covered servicemember.

WRNS Studio may enact additional rules consistent with FMLA provisions. For additional details on how FMLA applies to you, contact the Plan Administrator, or refer to the leave policies adopted by WRNS Studio.

USERRA: Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights generally include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in the Plan upon return from service with no waiting period or exclusions applied (and will run concurrently with any COBRA continuation coverage, to the extent allowed by law). These rights apply only to employees and their

dependents covered under the Plan before leaving for military service.

Applicable State Law

WRNS Studio shall permit you to continue participation in the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

Additional Health Plan Provisions

Qualified Medical Child Support Orders

The Plan may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child. You may obtain a copy of WRNS Studio's procedures governing QMCSO determinations, free of charge, by contacting the Human Resources Department.

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

Coverage of Dependent Children in Cases of Adoption

Group health plans that provide coverage for dependent children must provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the plan, irrespective of whether the adoption has become final.

Michelle's Law

All group health care coverage maintained under this Plan that requires a certification of student status for any period of dependent coverage shall comply with Michelle's Law. Eligibility for such coverage for a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the dependent child to lose eligibility for coverage under the group health care coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

Maternity-Related Hospital Length of Stay

Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act"). 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

Requirements for Fully-Insured Health Plans under State Law. Many states adopted maternity-related hospital length of stay requirements for fully-insured health plans that are not preempted by the Newborns' Act. The following is an overview of selected state law.

California**.** The California Newborns' and Mothers' Health Act of 1997 generally requires group policies issued in the State of California that provide maternity benefits to cover at least 48 hours of inpatient care after a normal vaginal delivery and at least 96 hours after a cesarean section, unless:

- The treating physician in consultation with the mother decides on an earlier discharge; and
- The policy covers one postdischarge follow-up visit for the mother and child within 48 hours when prescribed by the treating physician; this visit must be conducted by a licensed health care provider whose scope of practice includes postpartum and newborn care and must include parent education, training in breast or bottle feeding, and all necessary maternal and neonatal assessments. The treating physician in consultation with the mother must

determine whether the follow-up visit takes place in the office, at home, or in another facility.

New York. If a group health insurance plan issued in the State of New York provides benefits for pregnancy or childbirth, the plan also must provide postdelivery hospitalization for the mother and newborn child for a minimum of 48 hours for vaginal delivery, and 96 hours for a cesarean section delivery. If the mother agrees to a shorter hospital stay, the plan must provide at least one home care visit in addition to any other home health care provided by the health insurance policy. Maternity benefits also must include parent education, training and assistance in breast or bottle feeding, and any necessary newborn clinical assessments.

Women's Health and Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the medical plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which a mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Mental Health Parity and Addiction Equity

All group health care coverage maintained under this Plan that provides both medical and surgical benefits, as well as mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the issuer's plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the issuer's plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or issuer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

Under the Affordable Care Act ("ACA"), group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

GINA requires certain health plans to not discriminate based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as PHI under HIPAA.

To comply with this law, WRNS Studio asks that you not provide genetic information when responding to any request for medical information. 'Genetic information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

Wellness Program

WRNS Studio may offer one or more voluntary wellness programs or disease management programs ("Program") under this Plan that are reasonably

designed to promote the health and wellbeing of covered individuals. The Programs offer certain incentives or rewards for participation in a Program or for satisfying certain health standards.

If WRNS Studio chooses to offer a Program or Programs, its terms and conditions will be communicated to you and it will be administered in compliance with all applicable laws.

PLAN ADMINISTRATION

In General

WRNS Studio is the "Plan Administrator" of the Plan and a "Named Fiduciary" within the meaning of such terms as used in ERISA, as amended from time to time. WRNS Studio is the Plan's agent for service of legal process.

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

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

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

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

Privacy and Security of Information

In the administration of this Plan, WRNS Studio or one of its Business Associates may be required to use or disclose protected information for purposes of paying or causing to be paid benefits under this Plan. Please refer to the Plan's HIPAA Notice of Privacy Practices for additional details, which is available on request from the Plan Administrator.

WRNS Studio has established the following policy regarding the use and disclosure of protected health information ("PHI"). WRNS Studio hereby agrees to:

- Not use or disclose PHI other than as permitted or required by the Plan document or by law;
- Ensure that any agents to whom it provides PHI agrees in writing to the same restrictions and conditions that apply to the WRNS Studio;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of WRNS Studio;
- Not use or disclose PHI that is genetic information for underwriting purposes;
- Report to the Plan any use or disclosure of PHI inconsistent with Plan provisions;
- Make PHI available for purposes of access, amendment, and accounting as required under HIPAA;
- Make internal practices and records regarding PHI available to the HHS Secretary; and,
- Where feasible, return or destroy all protected health information received from the group health plan when no longer needed for the purpose for which disclosure was made.

In addition, if WRNS Studio creates, receives, maintains, or transmits any electronic PHI ("ePHI") on behalf of the Plan, WRNS Studio will:

- Implement safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan; and,
- Report breaches of unsecured ePHI to affected individuals, the HHS Secretary, and/or the media as required by HIPAA.

AFFORDABLE CARE ACT

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children available until they turn age 26. The mandate applies to any adult child of an employee whether or not he or she is a student, is eligible to enroll in other employer-sponsored group health coverage, is or is not married, lives or does not live at home, or is a dependent on the employee's tax return. Coverage must be offered even if the adult child does not live in a particular service area (but plans are not required to cover out-of-network services for these adult children).

The terms and conditions on which dependent coverage is provided cannot vary based on a child's age, unless the child is age 26 or older.

Pre-existing Condition Exclusions ("PCE")

Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's pre-existing condition. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

90-Day Waiting Period Limit

Group health plans may not apply a waiting period for coverage that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. ACA regulations permit plans to condition health coverage eligibility on an employee's completion of an employment-based orientation period of up to one month before application of the 90-day waiting period limit.

Essential Health Benefits

The ACA generally defines Essential Health Benefits to include the following broad categories of health care benefits. Essential Health Benefits covered under this Plan are subject to certain additional requirements under the ACA.

- Ambulatory patient services (i.e. outpatient care received without being admitted to the hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

ACA regulations further define Essential Health Benefits based on state-specific "benchmark" plans, or for self-funded plans, on the Federal Employees Health Benefit Program.

Lifetime and Annual Dollar Limits

Under the ACA, this Plan is prohibited from imposing lifetime or annual limits on the dollar value of Essential Health Benefits provided to any individual, regardless of whether the benefits are provided in-network or out-of-network. This Plan is not prohibited, however, from placing lifetime or annual dollar limits on specific covered benefits that are *not* Essential Health Benefits to the extent such limits are otherwise permitted under applicable federal or state law.

Cost-Sharing Maximum Limit

The ACA requires non-grandfathered group health plans to apply a uniform maximum limit for out-of-pocket expenses (deductibles, co-insurance, co-pays, or similar charges) on all Essential Health Benefits of no greater than the maximum amounts set annually by the Internal Revenue Service ("IRS") for high-deductible health plans as adjusted for inflation using the "premiums adjustment percentage."

- The overall cost-sharing limit only applies to benefits provided in-network. A plan may include out-of-network expenses at its discretion.

- Plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not Essential Health Benefits. See above in this Section for a list of Essential Health Benefits.

Patient Protections

Primary Care Provider Designation. If a non-grandfathered group health plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members.

Access to Pediatric Care. If a non-grandfathered group health plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider if such provider participates in the network of the Plan or issuer.

Access to Obstetrical or Gynecological Care. A participant, regardless of age, shall not need prior authorization from a non-grandfathered group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Emergency Services. A non-grandfathered group health plan that provides emergency services may not require preauthorization for those services. Emergency services must be provided regardless of whether the provider is in- or out-of-network without any time limit within which treatment must be sought.

In addition, the plan generally cannot impose any copayment or coinsurance for out-of-network emergency services that is greater than what would be imposed if the services were provided in-network.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for all the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual, as recorded by the plan:

Updated lists of the preventive services covered under this provision are available at www.healthcare.gov/coverage/preventive-care-benefits/.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Prescription Requirement for OTC Drugs

The ACA allows health flexible spending accounts ("Health FSA"), health reimbursement accounts ("HRA"), and other employer-sponsored health plans to reimburse expenses for medicines or drugs *only* if the medicine or drug (a) requires a prescription, (b) is available without a prescription (i.e., an over-the-counter ("OTC") drug) and the individual obtains a prescription, or (c) is insulin.

In addition, Health Savings Account ("HSA") purchases of OTC medicines and drugs without a prescription (except insulin) are not HSA qualifying medical expenses.

Prohibition on Rescissions

Group health plans are generally prohibited from rescinding the coverage of a participant. Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is *not* a prohibited rescission if:

- It is initiated by an individual and the plan, issuer, employer or sponsor does not take any actions to influence the individual's decision or to otherwise retaliate against the individual;
- It is initiated by the Health Insurance Marketplace;
- It only has a prospective effect; or,

- It is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage, including nonpayment of COBRA premiums.

Rescissions are permitted for fraud or the intentional misrepresentation of fact by the participant as prohibited by the terms of the plan. The plan must provide at least 30 days' advance notice to the affected participant before coverage may be rescinded, and only as permitted under Section 2702(c) or Section 2742(b) of the ACA. Rescissions are subject to internal claims, appeals, and external review procedures.

CLAIMS AND APPEAL PROCEDURES

To the extent they are consistent with the claims provisions of the Benefit Documents for each Component Plan, the procedures outlined below must be followed by Plan participants ("claimants") to obtain payment of benefits under this Plan. For purposes of this Section, the term "Administrator" means either the issuer or the Plan Administrator depending upon the policy or plan under which the claim has been filed.

Claims Procedures under Component Plans

The Benefit Documents provided by the Administrator for each component plan generally contain a detailed description of the Administrator's claims submission rules and claims appeal procedures for such component plan. This SPD sets forth the general claims and appeal requirements under applicable law, and these provisions will apply if the Benefit Documents of a component plan do not specify the claims procedures under the component plan. However, if there is a conflict between a provision of the claims procedures under this SPD and the claims procedures of the Benefit Documents of a component plan, you should follow the claims procedures of the component plan, as the component plan claims procedure provisions will govern.

The Administrator will act as, or will designate, a claims administrator to decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Administrator for a review of the denied claim. The Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. Note that under certain component benefit programs you may also have the right to obtain external review (that is, review outside of the Plan).

Please refer to Appendix B for a listing of claims and claims appeal contacts, addresses, and phone numbers.

Types of Health Claims

For purposes of group health plans subject to ERISA, there are four types of Health Claims: Urgent Pre-Service, Non-urgent Pre-Service, Concurrent, and Post-Service ("Health Claims").

- **Pre-Service Claims**. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Concurrent Claims.** A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

- **Post-Service Claims**. A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

Submission of Plan Claims

Unless specifically provided for otherwise in a Component Plan or pursuant to applicable law, a Health Claim for benefits must be filed within one year of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within this time frame.

The Plan, upon receipt of a written notice of a claim, will furnish you a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, you will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrator in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the Administrator receives the following information:

- The date of service;
- The name, address, phone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the participant; and,
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim. If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days (48 hours in the case of Pre-Service Urgent Care Claims) from your receipt of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

Claims of a Plan Providing Disability Benefits

For purposes of a Component Plan providing disability benefits, all claims and appeals for disability benefits shall be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Timing of Claims Decisions

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing.

For all claims, except those relating to group health plans and disability claims, if a claim is wholly or partially denied, the Administrator must notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan.

Extensions. This period may be extended by the Plan for up to 90 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 90-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Group Health Plan Claim Decisions

The Administrator shall notify you, in accordance with the provisions set forth below, of a denial (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following time frames:

- **Pre-Service Urgent Care Claims.** If you have provided all the necessary information, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  If you have not followed the Plan's procedures for filing a pre-service claim, or have not provided all of the information necessary to process the claim, then the Administrator will notify you as to the failure and the proper procedures for filing the claim or the specific information needed (as applicable) as soon as possible, but not later than 24 hours after receipt of the claim. If information is missing, you will be given at least 48 hours from receipt of the notice within which to provide the specified information. The Administrator will notify you of its determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded you to provide the information.

  No Extensions. No extensions are available in connection with Pre-Service Urgent Care Claims.

- **Pre-Service Non-Urgent Care Claims**. If you have provided all of the information needed to process the claim, the Administrator will notify you of its

decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. If an extension has been requested, the Administrator will notify you of its decision prior to the end of the 15-day extension period.

If you have not followed the Plan's procedures for filing a pre-service claim, the Administrator will notify you as to the failure and the proper procedures for filing the claim or the specific information needed (as applicable) as soon as possible, but not later than 5 days after receipt of the claim.

Extensions. The adverse benefit determination notification period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary because you have not provided all of the information needed to process the claim, the Administrator will notify you of the required information needed to file the claim. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

- **Concurrent Claims:**

  Plan Notice of Reduction or Termination**.** If the Administrator is notifying you of a reduction or termination of a course of treatment previously approved by the Component Plan (other than one that occurs by reason of Component Plan amendment or termination), the Administrator will notify you of its decision sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

  Request by Claimant Involving Urgent Care**.** If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as you make the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If you submit the request less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care time frame.

  Request by Claimant Involving Non-Urgent Care. If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim does not involve Urgent Care, the request will be treated as a new benefit claim and will be decided within the time frame appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

- **Post-Service Claims.** If you have provided all of the information needed to process the claim, the Administrator will notify you of its decision within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  Extensions. This period may be extended by the Component Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Component Plan expects to render a decision.

  If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Disability Claim Decisions

For purposes of disability plans subject to ERISA, the Administrator must notify you of a disability claims determination within 45 days after receipt of your claim.

Extensions. This period may be extended by the Plan for two additional 30-day periods provided, that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Component Plan and notifies you, prior to the expiration of the initial 45-day processing period (or prior to the end of the 30-day extension, as applicable),

of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Any notice of extension will specifically explain the standards on which entitlement to a benefit is based and the unresolved issues that prevent a decision on the claim (including any additional information needed to resolve such issues). You will be given at least 45 days to provide such information.

Notice of Denial

The notice of an adverse benefit determination ("Notice of Denial") shall be written or in electronic form (in compliance with ERISA regulations), or oral in the case of a Pre-Service Urgent Care Claim, as long as a written or electronic notice is furnished to you within 3 days of the oral notice, and shall set forth:

- The specific reason for the adverse benefit determination;
- Specific references to the pertinent Component Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;
- An explanation of the Plan's claims appeal procedures; and,
- Your right to bring a civil action under ERISA Section 502(a).

For claims related to an adverse benefit determination by a group health Component Plan, the Notice of Denial shall also include:

- Specific references to the internal rule, guideline, protocol or other similar criteria on which the adverse benefit determination is based, or a statement that such criteria was relied upon in making the adverse benefit determination and notice of where and how to obtain a copy free of charge;
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how to obtain a copy free of charge; and,
- For purposes of Pre-Service Urgent Care Claims, a description of the expedited review process.

For claims related to an adverse benefit determination with respect to disability benefits, the Notice of Denial must include:

- Specific references to the internal rule, guideline, protocol or other similar criteria on which the adverse benefit determination is based, or a statement that such criteria was relied upon in making the adverse benefit determination and notice of where and how to obtain a copy free of charge; and,
- An explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request.

For claims for disability benefits filed under this Plan on or after January 1, 2018 (or such later date provided in any disability Component Plan document, so long as compliant with applicable claims procedure regulations), the following provisions apply:

- The notice of denial also must include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with (or not) (i) the views presented by the claimant to health care and vocational experts that examined the claimant, (ii) the views of vocational experts or medical experts whose advice was obtained (whether or not relied upon), or (iii) the disability determination made by the Social Security Administration;
  - An explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request;
  - Specific internal rules, guidelines, protocols or other similar criteria on which the denial is based, or a statement that such criteria do not exist; and
  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- The term "adverse benefit determination" also means any rescission of disability coverage with respect to the participant or beneficiary.

Appeals of Adverse Benefit Determinations

The Administrator maintains procedures which provide you with a reasonable opportunity to appeal an adverse benefit determination and under which there will be a "full and fair review" of the claim and the adverse benefit determination. You or your duly authorized representative may:

- Request a review by providing written notice to the Administrator;
- Submit written comments, documents, records and other information relating to the claim; and,
- Upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

In addition, under ACA, non-grandfathered group health plans must implement an effective internal appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes;
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

Timing of Appeals

You shall have a reasonable opportunity to appeal a claim denial to the Administrator for full and fair review provided that the Administrator receives the written appeal within the following timeframes:

- All Claims Other Than Group Health Plan Benefits and Disability Benefits: 60 days following receipt of the Notice of Denial.
- Disability Benefits Claims: 180 days following receipt of the Notice of Denial.
- Group Health Plan Benefits Claims: 180 days following receipt of the Notice of Denial. For Pre-Service Urgent Care claims, please refer to Appendix B for a listing of appeals contacts, addresses and phone numbers.

Timing of Notification of Appeals Decision

The period of time within which the Component Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing. The Administrator shall notify you of the Component Plan's benefit determination on review within the following time frames:

- All Claims Other Than Group Health Plan Benefits and Disability Benefits: The Administrator will notify you within 60 days after receipt of the appeal. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
- Group Health Plan Claims:

  Pre-Service Urgent Care Claims**.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

  Pre-Service Non-urgent Care Claims**.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

  Concurrent Claims**.** The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

  Post-Service Claims**.** Within a reasonable period of time, but not later than 60 days after receipt of the appeal**.**
- Disability Benefits Claims: 45 days after receipt of the appeal. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

Appeals Decision

The decision of the Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how you can obtain a copy. If the health plan is subject to state law, you may have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services. Please refer to your health plan booklet or evidence of coverage for details.

For claims for disability benefits submitted on or after January 1, 2018 (or such later date provided in any Component Plan document, so long as compliant with applicable claims procedure regulations):

- An appeals decision for a disability claim filed under this Plan shall also include a discussion of the decision, including an explanation of the basis for disagreeing with (or not) (i) the views presented by the claimant to health care and vocational experts that examined the claimant, (ii) the views of vocational experts or medical experts whose advice was obtained (whether or not relied upon), or (iii) the disability determination made by the Social Security Administration. Such notification shall also include an explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request, as well as specific internal rules, guidelines, protocols or other similar criteria on which the denial is based, or a statement that such criteria do not exist.
- If the Plan fails to strictly adhere to all the requirements with respect to a claim or appeal related to disability benefits, you will be deemed to have exhausted the administrative remedies available under the Plan, and will be entitled to pursue any available remedies under ERISA section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. However, the administrative remedies will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

Second Appeal

If specified in the Benefit Documents for each component plan or in documentation given to you by the claims administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

If a second appeal is provided by a component plan that is not a group health plan, notification of your benefit determination with respect to the second appeal will be made in accordance with the same guidelines as those outlined above for the first appeal. If a second appeal is provided by a component plan that is a group health plan, notification of your benefit determinations with respect to any one of the two appeals will be made according to the following schedule:

- Pre-Service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-Service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.
- Post-Service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Full and Fair Review

The Plan Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim. For purposes of any group health plan or disability plan, review will be conducted without deference to the original determination. Such review shall be conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the original determination or a subordinate of such individual. If the decision was based in whole or in part on a medical judgment, the appeal shall be made with consultation with the appropriate independent health care professionals, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of such person. Medical or vocational experts whose advice was obtained in making the adverse benefit determination will be identified, regardless of whether such advice was relied upon in making the determination.

A non-grandfathered group health plan must provide you, free of charge, with any new or additional evidence considered by the plan in connection with the claim and the rationale behind the adverse benefit determination. Such evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond.

For disability benefit claims submitted on or after January 1, 2018 (or such later date provided in any disability Component Plan document, so long as compliant with applicable claims procedure regulations), before the Plan issues an adverse benefit determination on review with respect to disability benefits, the Plan will provide the claimant, free of charge, any new or additional evidence considered by the Plan in connection with the disability claim and any new or additional rationale behind the adverse benefit determination. Such evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond.

If 10% or more of the population residing in the county in which a non-grandfathered group health plan or disability plan claims notice or appeals decision is sent is literate only in the same non-English language, the Plan Administrator will provide applicable notifications and assistance with filing claims and appeals in that non-English language in accordance with applicable regulations.

Group Health Plan External Review

If a claimant's internal appeal is denied, the claimant may have the right to have the claim reviewed by an independent reviewer organization (IRO), not employed by the health plan, through an external review process. This applies to claims that involve medical judgment as determined by the external reviewer or a rescission of coverage. Claimants shall be allowed at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination. External review of claims shall be provided in accordance with and pursuant to all applicable laws. In the event the IRO's decision is to reverse the Plan's benefits denial, the Plan shall immediately provide coverage or payment for the claim (including immediate authorization or payment of benefits).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

The following federal COBRA provisions apply to certain health care benefits offered under this Plan (e.g., medical, dental, vision, Health FSA). Nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you and your family may also become eligible for other coverage options that may cost less than COBRA continuation coverage, including through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options. You can learn more about many of these options at www.healthcare.gov.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health 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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events 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;
- The employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

- The child stops being eligible for coverage under the Plan as a dependent child.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify WRNS Studio of any of these qualifying events.

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

Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to:

WRNS Studio
Attn: Melinda Rosenberg
501 Second Street, 4th Floor, Suite 402
San Francisco, CA 94107
415-489-2224

You may lose your right to elect COBRA coverage if proper procedures are not followed.

Electing COBRA Coverage

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

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

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described below.

- When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage can last for up to a total of 36 months.
- When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.
- Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally can last for only up to a total of 18 months.

Special Rule for Health FSAs. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims

submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA coverage will only last until the end of the plan year during which the qualifying event occurred. The use-it-or-lose rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year and COBRA coverage will be terminated. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs.

These extension opportunities also do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

Notification Requirement. You must notify WRNS Studio of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. You must provide this notice to:

WRNS Studio
Attn: Melinda Rosenberg
501 Second Street, 4th Floor, Suite 402
San Francisco, CA 94107
415-489-2224

You may lose your right to extend COBRA coverage if proper procedures are not followed.

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify WRNS Studio in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify WRNS Studio in writing of the Social Security Administration's determination of disability within 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

Second Qualifying Event Extension of COBRA Coverage. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify WRNS Studio in writing of the second qualifying event within 60 days after the date of the second qualifying event.

Extension of Fully-Insured Coverage under California State Law. COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded

medical plans. *The combination of federal and state COBRA coverage may not exceed 36 months in any event.* The 36-month period dates back to the original qualifying event.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

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

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

Cost of COBRA Coverage

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

Payment for COBRA Coverage. If you elect continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

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

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

Plan Contact Information

WRNS Studio Health & Welfare Plan
WRNS Studio
501 Second Street, 4th Floor, Suite 402
San Francisco, CA 94107
415-489-2224

STATEMENT OF ERISA RIGHTS

As a participant in the WRNS Studio Health & Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents 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 Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator

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

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

OTHER IMPORTANT INFORMATION

Refunds and Rebates

Under ERISA, the Plan Administrator of a group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio ("MLR") rebates from group health insurers. A rebate may be an asset of the Plan, which must be used for the benefit of the participants covered by the applicable Component Plan. Any refunds or rebates attributable to benefit premiums paid by the Plan Administrator will be retained by the Plan Administrator.

Generally, any amounts attributable to premium contributions paid by participants must be distributed within 90 days of receipt to the applicable participants or applied as an enhancement in benefits or a reduction in premium contributions. Participants should contact the Plan Administrator for any additional information on how a refund or rebate will be used.

Non-Assignment of Benefits

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

Legal Actions

All legal action commenced under the Plan shall be brought in the federal court of proper jurisdiction in the State of California.

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

- Before bringing any lawsuit seeking benefits under a Component Plan, a claimant must complete the applicable claims procedure set out in the Plan or the Component Plan (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the claimant's right to file a lawsuit with respect to the claim.
- In the case of a Component Plan that is self-funded by WRNS Studio, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the insurance company or the Plan shall be determined by the terms of the applicable Component Plan.

Amendment and Termination

WRNS Studio intends to maintain the Plan indefinitely but is under no obligation to continue the Plan and can modify, amend, or terminate the Plan by providing written notice to the Plan participants. In amending or terminating the Plan, WRNS Studio cannot retroactively reduce the benefits to which a participant is entitled prior to the termination or amendment.

Controlling Documents

The information contained in this SPD is only a general discussion of the relevant provisions of the Plan found in the official Plan document. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan. The official Plan document is available for your review at the offices of WRNS Studio.

APPENDIX A

WRNS STUDIO HEALTH & WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Insurance Policy Issuers and Contract Administrators

Fully-Insured Plans	Policy No.	Type of Benefit
Kaiser Foundation Health Plans, Inc. 1 Kaiser Plaza Oakland, CA 94612	652441	Medical – HMO(California)
Kaiser Foundation Health Plan Inc. 711 Kapiolani Blvd. Honolulu, HI 96813-5276	3003	Medical – HMO (Hawaii)
Standard Insurance Company 900 SW 5th Ave Portland, OR 97204	158968	Dental – PPO Basic Life/AD&D Short-Term Disability Long-Term Disability
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670	30020260	Vision

Self-funded Plans	Contract No.	Type of Benefit
Cigna 900 Cottage Grove Road Bloomfield, CT 06002	62015	Medical – PPO (Open Access Plus) Medical – HDHP (HSA Open Access Plus)
Navia Benefit Solutions 11400 SE 6th St, Suite 125 Bellevue, WA 98004	—	Health FSA

APPENDIX B

WRNS STUDIO HEALTH & WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Claims Administrator Contact Information

Use the address and phone number provided on your ID Cards if different.

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	**Phone No.**	**Online**
Medical – Cigna	Cigna Attn: Medical Claims P.O. Box 188061 Chattanooga, TN 37422-8061 *Claims Appeals:* Cigna Attn: Claims Appeals P1000 Great West Drive Kennett, MO 63857	866-494-2111	my.cigna.com/
Medical – Kaiser California	Kaiser Permanente Attn: Claims Administration P.O. Box 12923 Oakland, CA 94604-2923 *Claims Appeals:* Kaiser Permanente Attn: Provider Dispute Services Unit P.O. Box 23100 Oakland, CA 94623	800-390-3510	healthy.kaiserpermanente.org/
Medical – Kaiser Hawaii	Kaiser Permanente Attn: Claims Administration P.O. Box 378021 Denver, CO 80237	877-875-3805 *Appeals:* 800-966-5955	healthy.kaiserpermanente.org/
Dental	The Standard Attn: Group Claim Office P.O. Box 82622 Lincoln, NE 68501-2622	800-547-9515	www.standard.com/ *Fax claims to 402-467-7336*

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	**Phone No.**	**Online**
Vision	VSP Attn: Claims Department P.O. Box 997105 Sacramento, CA 95899-7105 *Claims Appeals:* VSP Vision Care Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95670	800-877-7195	www.vsp.com/
Health FSA	Navia Benefit Solutions Attn: FSA Claims P.O. Box 53250 Bellevue, WA 98015-3250	800-669-3539	www.naviabenefits.com/ *Fax claims to 866-535-9227*
Life/AD&D Disability	The Standard Attn: Employee Benefits Dept. P.O. Box 2800 Portland, OR 97208	800-628-8600	www.standard.com/

APPENDIX C

WRNS STUDIO HEALTH & WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

An employee who is *reasonably* expected to be a full-time employee as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified below:

Employee Class	Line(s) of Coverage	Effective Date of Eligibility	Working Hours Requirement
Full-Time Employees	All	First day of the month following date of hire	30 or more hours of service per week

Dependent Eligibility

Date of Eligibility. Coverage for dependents, if elected, begins on the date employee coverage begins, unless specified otherwise under the applicable Component Plan's Benefit Documents.

Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions (spouse, domestic partner, child(ren)) shall have the same meaning set forth in each applicable Component Plan's Benefit Documents, or, if not defined in those documents, in accordance with the policies adopted by WRNS Studio.

Rehire Rule

A terminated employee who is rehired prior to the end of a certain period of time after the date of termination may be credited with time met towards the employment waiting period as of the date of termination. Otherwise, a terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and participation requirements. Review the rehire rules set forth in each applicable Component Plan's Benefits Documents for further details.

Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

An employee who is *not* reasonably expected to be a full-time employee as of his or her start date (Variable Hour Employee), or an employee who is reasonably expected to have fewer than 30 hours of service per week (Part-Time Employee), or an employee in a position for which the customary annual employment is six months or less (Seasonal Employee), will be determined to be eligible or ineligible for benefits based on whether such employee satisfies the full-time employee hourly requirements under the ACA Measurement Method adopted by WRNS Studio.

In the event an employee is hired into this class of employment, he or she generally will become eligible for benefits after averaging 130 or more hours of service per month during a period of time spanning a specific number of months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months (referred to as the "Stability Period"). If applicable, details regarding each of these periods and the rules for counting hours of service are available upon request to the Plan Administrator.

APPENDIX D

WRNS STUDIO HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Premium Assistance under Medicaid and CHIP

If you live in certain states, you may be eligible for assistance paying your employer-provided health plan premiums. The most current list of states providing such subsidizes is available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc. Effective as of January 31, 2018, if you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums:

ALABAMA – Medicaid
http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program:
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/ default.aspx

ARKANSAS – Medicaid
http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid and CHIP
Medicaid: https://www.healthfirstcolorado.com
Medicaid Customer Contact Center: 1-800-221-3943
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800-359-1991

FLORIDA – Medicaid
http://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64:
http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid:
http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
https://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/ombp/nhhpp/

Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
www.eohhs.ri.gov
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov/
CHIP: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid & CHIP:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
http://mywvhipp.com/
Phone: 1-855-699-8447

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gyov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565