ERISA INFORMATION
FOR THE PACE EMPLOYEE WELFARE PLAN

Amended and Restated Effective as of July 1, 2024

This booklet, together with the applicable insurance policies, certificates of coverage or other component plan benefit booklets serve as both the official plan documents and as the summary plan descriptions for the benefits provided under the Pace Employee Welfare Plan (unless otherwise noted, referred to collectively as "Plan").

Pace reserves the right to amend, suspend or terminate the Plan, or any benefits thereunder, at any time and for any reason.

Only Pace, Plan Administrator or the designated claims fiduciary is authorized to make administrative interpretations of the provisions of any Plan and will do so only in writing. You should not rely on any representation—whether verbal or in writing—that any other individual may make concerning Plan provisions and your entitlement to benefits under the Plan.

PACE
2432 Greenburg Pike
Pittsburgh, PA 15221

Table of Contents

IMPORTANT Information

As stated above, this booklet together with the applicable insurance policies, certificates of coverage or other component plan benefit booklets that you receive serve both as the official plan documents and as the summary plan descriptions for the benefits provided under the Plan and sponsored by the Organization.

Except as otherwise provided, in the event of a conflict between the benefits information in this booklet, if any, and the applicable insurance policies, certificates of coverage or other benefit booklets, the insurance policy, certificate of coverage or other benefit booklet will prevail. The applicable insurance policies, certificates of coverage or other benefit booklets are intended to be read together with this booklet, as appropriate. Additional copies of the insurance policies, certificates of coverage and other benefit booklets are available through the Plan Administrator.

This booklet includes information about the administration of the benefits under the Plan and your rights under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

Except as otherwise provided herein, this booklet and the applicable insurance policies, certificates of coverage or other benefit booklets replace all summary plan descriptions previously issued with regard to the benefits provided under the Plan.

Se usted neccessita ayuda sobre la informacion contenida en este plan en Español, un representante lo asistira si usted lo require.

The component medical plan(s) under the Plan are not grandfathered under the terms of the Patient Protection and Affordable Care Act.

Plan Benefits

The Plan currently provides health, prescription drug, dental, vision, long-term disability, life and accidental death and dismemberment benefits.

Plan Sponsor

The Plan Sponsor for each of the benefits under the Plan is Pace (Organization).

The Internal Revenue Service assigns every employer an Employer Identification Number (EIN). The Plan Sponsor's EIN is 25-1186708. If you need to write to a government agency about a benefit plan, use this number along with the Plan name, Plan identification number (501), and the Plan Sponsor's name.

Plan Administration

■ Plan Administrator

The Organization is the Plan Administrator for the benefits provided under the Plan. For many of these benefits, the Organization has appointed an insurer, committee, or a third party administrator of services to act on its behalf.

You can contact the Plan Administrator at the following address:

Pace
2432 Greensburg Pike
Pittsburgh, PA 15221

The phone number of the Plan Administrator is 412-244-1900.

The Organization provides indemnification against liability, costs, and expenses incurred by any employee or member of a board of trustees of the Organization acting as a Plan fiduciary other than those that may result from the negligence, willful misconduct, or deliberate breach of fiduciary duty of that person. This indemnification is in addition to any other rights of the fiduciary. Fidelity bonds cover Plan fiduciaries and other parties having authority to handle Plan funds to the extent required by ERISA Section 412 or other applicable law.

Employees, officers, directors, and agents of the Organization shall not be personally liable for any action taken in good faith in reliance on any tables, valuations, certificates, or reports furnished by any duly appointed advisor to the Plan, such as an actuary, accountant, legal counsel, and/or physician.

■ Discretionary Authority of Plan Administrator and Plan Fiduciaries

The Plan Administrator has the full and discretionary authority and power to administer and construe the Plan (and any component plans there under) except to the extent that such powers have been delegated, such as to an administrator for claims determinations. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- Allocate fiduciary responsibilities and designate one or more persons to carry out those responsibilities
- Designate agents to carry out responsibilities other than fiduciary responsibilities
- Employ legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan
- Perform or cause to be performed anything necessary, appropriate, or convenient in the administration of the Plan
- Except as otherwise provided below, to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan, which

determinations shall be final and conclusive on all persons claiming benefits under the Plan; provided, however, that if an insurance certificate sets forth a specific claims procedure, such provisions shall apply for purposes of that component plan, consistent with the "Claims and Appeals Procedures" section below; and

- To make and enforce such rules and regulations as it may deem necessary or proper for the efficient administration of the Plan.

■ Type of Funding and Administration

The Plan Administrator has delegated authority under the Plan to the respective insurance companies or third party administrators to administer benefit claims under the applicable component plans. The Plan Administrator may designate different administrators from time-to-time, at the Plan Administrator's discretion. The administrator for claims determinations for each benefit is identified in the chart in the Summary Plan Information section below. For some or all of the benefits, you may be required to contribute all or a portion of the cost of coverage through payroll deductions. The Plan Administrator administers the Plan for the exclusive benefit of participants and beneficiaries.

For component plans provided through insurance, the insurance company, not the Organization or the Plan Administrator, is responsible for paying the actual cost of eligible claims you and your dependents incur. The insurance company providing such benefits has the full and final discretionary authority to interpret the component plan terms, determine benefit eligibility and is responsible for ensuring that claims are paid according to the provisions of the component plan. Such determinations shall be final and conclusive on all persons claiming such benefits.

For component benefits that are self-funded by the Organization, the Organization, not the insurance company, is responsible for paying the actual cost of eligible claims you and your dependents incur out if its general assets.

In either case, the applicable claims administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and interpretation of the respective component benefit. This includes, without limitation, the power to construe any applicable administrative services agreement, to determine all questions arising under the plan, to resolve the claims, complaints and appeals of covered persons and to make, establish and amend the rules, regulations and procedures with regard to the component benefit.

■ Plan Expenses

The Organization has the option of paying certain expenses in connection with the administration of the Plan and reserve the right to allocate and reallocate administrative costs between the Organization and participants in the Plan.

■ Clerical Errors

Any clerical or similar error in keeping pertinent records or a delay in making an entry will not invalidate coverage or otherwise validate in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

■ Misrepresentation

If a Plan participant or a person eligible for coverage under the Plan makes any intentional misrepresentations or uses fraudulent means in applying for coverage, making a change in their existing coverage election, or filing a claim for benefits, his or her coverage may be subject to immediate termination of coverage, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity.

■ Limitations on Actions

Notwithstanding the provisions of any applicable insurance policies, certificates of coverage or other component plan benefit booklets, any claims or action filed in court against or with respect to the Plan, the Plan Administrator, or the Plan Sponsor must be started within the following time frames.

- Claims for benefits (including eligibility) cannot be started before all internal administrative claims and appeals procedures have been exhausted, and must be started no later than 180 days after the date of the written determination of the appeal of the claim.

- All other claims with respect to any self-insured benefit (including claims for an interference with ERISA protected rights) must be started within two (2) years of when the Participant knew or should have known of the actions or events that gave rise to the claim.

- All other claims with respect to any fully insured benefit must be filed within the same time period specified by the insurance company in the applicable insurance policies, certificates of coverage or other component plan benefit booklets.

Any claim or action not started within the above timeframes will be void and forfeited.

■ Acceptance and Cooperation

Any individuals seeking or accepting benefits under the Plan are considered to have accepted its terms. All individuals claiming any interest in or benefits from the Plan agree to perform any act and to execute any documents that may be necessary or desirable to carry out the Plan or any of its provisions.

■ Governing Law

The Plan is to be interpreted under federal law, including ERISA, and under the laws of the Commonwealth of Pennsylvania, to the extent state law is not preempted.

■ Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include

children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. In this case, you will be required to pay the applicable contribution amount for yourself, the child, and any other covered dependents. You may obtain a copy of the Organization's procedures governing QMCSO determinations, free of charge, by contacting Human Resources.

- **Third Party Beneficiaries; Assignment**

  The Plan is not intended to benefit any person other than covered individuals. Other than direct payment to health care providers, a covered individual cannot assign or alienate (voluntarily or involuntarily) the covered individual's rights under or interest in the Plan. Any attempt to assign or alienate these rights or interests is void.

Plan Limitations

Nothing contained in the benefit booklets, insurance booklets or this booklet creates any employment contract or in any way alters the Organization's policy and practice of employment at will contained in the Organization's employment application, handbook and policy manuals.

Plan Amendment and Termination

The Organization reserves the right at its discretion to end or amend the Plan, or any provision, benefit coverage or contribution under any component benefit under the Plan, at any time, for any reason. Contributions, premium rates, deductibles, out-of-pocket maximums, benefit levels, covered benefits, and other plan features may be affected. Such changes may affect any or all participants.

If the Plan is modified, any claims incurred prior to the date of modification will be paid in accordance with the Plan in effect at that time. Any expense incurred after the amendment date will be paid in accordance with the new Plan provision.

If the Plan is terminated, any eligible claims incurred before the date of termination will be paid if submitted to the Claims Administrator within a reasonable period of time, as established by the Plan.

Plan Records

The Plan's records are kept on the basis of a "plan year" that had begun on September 1 and ended on August 31. The Plan had a short plan year that began on September 1, 2018 and ended on June 30, 2019. After June 30, 2019, the Plan's plan year shall begin on July 1 and end on June 30.

Reimbursement, Recovery of Overpayment, and Subrogation

As a condition for receiving benefits under the Plan, you agree to and grant the Plan the rights of reimbursement, recovery of overpayment and subrogation. To the extent that a benefit booklet or insurance certificate also contains provisions regarding reimbursement, recovery of overpayment, and/or subrogation, this section and the applicable provisions of such booklet or certificate both apply so as to grant the Plan the greatest possible rights.

Agent of Service for Legal Process

Any legal process against the Plan in the event of an unresolved dispute over benefit plan provisions should be served on the Plan Administrator.

Claims and Appeals Procedures

Claims for benefits. If you feel an error has occurred in your records or in processing your claim for benefits, you should know that claims and appeals procedures are available to every participant and beneficiary. In general, your claim(s) for benefits will be processed according to the procedures set out in the applicable insurance policy, certificate of coverage, benefit booklet or other component plan document.

As discussed above, the Plan Administrator has delegated to the insurance companies or third party administrators of the applicable component benefit plans the full authority to administrator and make final determinations concerning all claims for benefits and appeals of denied claims for benefits.

To the extent that a component plan provides for voluntary levels of appeal, the Plan agrees (i) to waive the right to assert that you failed to exhaust your administrative remedies by not submitting the dispute to the voluntary level of appeal; (ii) that the statute of limitation will be tolled during the time that such voluntary level of appeal is pending; and (iii) that you may elect to submit the benefit dispute to the voluntary level of appeal only after you have exhausted the appeals permitted under Department of Labor regulations.

If the Plan Administrator learns of conflicting benefit claims made by two or more claimants, the benefit may be withheld until the conflict is resolved by one of the following: (a) agreement between the claimants; (b) a final judicial determination of entitlement to benefits; or (c) any other procedure reasonably calculated to protect the Plan from paying the same benefit more than once. If there is both a conflict between claimants and a dispute between one of those claimants and the Plan regarding benefit payment, the Plan Administrator may allow the processing of the request for benefits under normal appeal procedures before resolving the conflict between claimants.

Claims Regarding Plan Eligibility. Claims for eligibility will normally be approved or denied by the Plan Administrator within 30 days after they are received. If your claim is denied, the written notice you receive will tell you why it was denied and will refer to the Plan provisions upon which the decision was based. The notice will also tell you about any additional information which may be necessary for your claim to be approved.

You may appeal the denial of your claim by writing the Plan Administrator and stating that you wish to appeal. The Plan Administrator will consider your written appeal provided it is received no more than 30 days after you have received notice of the denial of your claim. You may submit written comments, documents, records, and other information relating to your claim.

If you appeal, the Plan Administrator will review your appeal and any additional information you furnish. Normally the Plan Administrator will decide your appeal within 15 days after it is received. In unusual circumstances, it may be necessary to delay the final decision of your appeal for an extra 15 days. You will be notified of any delay within 15 days after your appeal is received. After your appeal is decided, the Plan Administrator will tell you both how it was decided and what Plan provisions the Plan Administrator relied upon.

Your Rights Under ERISA

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

■ Your Right to Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Receive, if applicable, a summary of the annual financial report for the Plan. If applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

■ Your Right to Continue Group Health Plan Coverage

Under ERISA, you may be entitled to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the “COBRA Continuation Coverage” Appendix for more information regarding your COBRA continuation coverage rights.

■ Your Right to 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 the Plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other participants. No one, including your employer or any other person, may fire

you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

How to 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 the documents 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. 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. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-275-7922 or go to www.dol.gov/ebsa.

Summary Plan Information

Pace Employee Welfare Plan

Plan Number: **501**

Type of Plan: **Welfare benefit plans**

Type of Benefit	*Type of Financing and Access to Benefit Booklets*	*Claims Administrator*
Health, Prescription Drug	Self-insured Access the benefit booklet that contains the full details of the coverage you enrolled in here: https://acshic.com/your-benefits/members/	Highmark Blue Cross Blue Shield P.O. Box 226, Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15230 888-258-3428 www.highmarkbcbs.com Final determinations made by: Allegheny County Schools Health Insurance Consortium AON Risk Services Central, Inc. 625 Liberty Avenue, 27th Floor Pittsburgh, PA 15222-3110
Vision	Self-Insured Access the insurance certificate that contains the full details of the coverage you enrolled in here: https://www.acshic.com/benefits---vision	Davis Vision 159 Express Street Plainview, New York 11803 (516) 932-9500 www.davisvision.com Final determinations made by: Allegheny County Schools Health Insurance Consortium AON Risk Services Central, Inc. 625 Liberty Avenue, 27th Floor Pittsburgh, PA 15222-3110
Dental	Self-Insured Access the insurance certificate that contains the full details of the coverage you enrolled in here: https://www.acshic.com/benefits-dental	United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110 800-332-0366 www.ucci.com Final determinations made by: Allegheny County Schools Health Insurance Consortium AON Risk Services Central, Inc. 625 Liberty Avenue, 27th Floor Pittsburgh, PA 15222-3110

Employee Assistance Program	Insured Lytle EAP Partners 200 Cedar Ridge Drive, Suite 208 Pittsburgh, PA 15205 (800) 327-7272	Lytle EAP Partners 200 Cedar Ridge Drive, Suite 208 Pittsburgh, PA 15205 (800) 327-7272 www.lytleeap.com
Long-Term Disability Life and Accidental Death and Dismemberment	Insured The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68103	The Lincoln National Life Insurance Company PO Box 2609 Omaha, NE 68103 LincolnFinancial.com Claims@LFG.com 866-783-2255 (Life Claims) PO Box 2649 Omaha, NE 68103

Appendix – Special Information Applying to the Benefits described in this booklet

APPENDIX -- Employee Eligibility and Commencement of Coverage

■ Eligibility

In general, only employees of the Organization who satisfy the eligibility and enrollment requirements (including any minimum hour and waiting period requirements) set forth in the applicable insurance policies, certificates of coverage or other component plan benefit booklets benefits may participate in the corresponding component benefit. For those that satisfy those eligibility and enrollment requirements, coverage generally will commence on the first day of the month following the date the employee becomes eligible.

An employee is considered an active employee or actively employed for purposes of administering the benefits under this Plan (including making eligibility determinations) if the employee is present and capable of carrying out the assigned job duties of the Employer. **However, for purposes of the group health plan benefits, employees who are absent from work due to a health related disability, maternity leave, or other health factor will be considered actively employed.**

Medical Plan. Solely for purposes of the medical plan, employees classified by the Organization as regular full–time employees, or part-time and temporary employees shall be eligible to participate if they are regularly scheduled to work 30 or more hours per week, as determined, where applicable under the IRS' measurement period regulations and the Plan's administrative procedures.

Employee Assistance Program (EAP). All employees of the Organization are eligible to participate in the EAP.

Insured Fringe Benefits Other Than the Medical Plan and EAP. For purposes of the component benefits under this Plan other than the medical plan and the EAP, the following categories of employees are eligible to participate:

- employees classified by the Organization as full-time employees, regularly scheduled to work 37.5 or more hours per week.

Note, however, that in general the following classifications of employees are not eligible to participate in any benefits under the Plan described in this booklet:

- **Part-time employees**. Beginning on and after July 1, 2019 part-time employees shall no longer be eligible for coverage under the Plan, except with respect to the medical plan and provided they meet the eligibility requirements for that plan. For purposes of the Plan, part time shall mean that the employee is regularly scheduled to work fewer than 37.5 hours per week.

- **Temporary employees**. Except with respect to the medical plan and provided they meet the eligibility requirements for that plan. For purposes of the plan, Temporary employees shall mean employees who may work up to 40 hours per week, but in

a position of specified duration, which does not alter the employment at will relationship unless there is a written signed contract between employee and Pace to the contrary.

- **Payroll service or agency employees**. A payroll service or agency employee means an individual (a) for whom the direct payer of compensation with respect to the performance of services for the Organization is any outside entity, including but not limited to a payroll service or temporary employment agency, rather than by the Organization's internal corporate payroll system; or (b) who is paid directly by the Organization, but not through an internal corporate payroll system (e.g., through purchase order accounts); or (c) designated by the Organization as an independent contractor, either through the terms of an agreement with such individual or otherwise. The determination whether an individual is a "payroll service or agency employee" shall be made by the Organization, in its sole discretion, based solely upon these criteria, without regard to whether the individual is considered a common law employee of the Organization for any other purpose.

Where dependent coverage is provided, dependents of such eligible employees are eligible to the extent they satisfy the eligibility requirements set forth in the applicable insurance policies, certificates of coverage or other component plan benefit booklets benefits. For plan years beginning on and after July 1, 2019, domestic partners and common law spouses shall not be considered eligible for coverage under the Plan; provided, however, that domestic partners and common law spouses that were covered under the medical, dental, and/or vision fringe benefits on June 30, 2019, shall be eligible to elect continuation coverage similar to that provided under COBRA. This means, for example, that if coverage ends for a domestic partner on June 30, 2019, because of this provision, the domestic partner will be treated as if he or she is a COBRA qualified beneficiary with a qualifying event of June 30, 2019. If the domestic partner would like to continue such coverage, he or she would have to make timely election and payment for such coverage as if the individual was a COBRA qualified beneficiary. Domestic partners and common law spouse also will be offered any conversion options available under the plans.

The Plan intends that eligibility determinations for medical coverage shall be made in a manner consistent with the final regulations issued by the Internal Revenue Service on February 10, 2014, and related guidance, implementing the employer responsibility provisions of the Affordable Care Act (ACA) under section 4980H of the Internal Revenue Code. Your eligibility for medical coverage under the Plan is based on your classification as an Organization employee, as well as your hours of service. The Plan Administrator or its designee and the Plan's third-party administrators have the right the right to request any information needed to determine or confirm an individual's eligibility for benefits under this Plan.

Appendix – Special Information Applying to the Benefits described in this booklet

■ Enrollment

In general. If you are an eligible employee and would like to participate in a component benefit under the Plan, you must enroll yourself and, if applicable, your eligible dependents (as described above) in the time and manner determined by the Organization. In order to enroll, you must complete the applicable enrollment requirements for the applicable components. In completing the enrollment, you will be required to represent to the best of your knowledge and belief that all information contained in the enrollment (including, but not limited to, applications, questionnaires, forms, or statements) submitted to the Plan Administrator or its designee is true, correct, and complete. Coverage under a component benefit is subject to the condition that all such information is true, correct and complete. Any material misrepresentation intentionally made by you in providing this information may result in termination of benefits under the plans for you and your dependents. In addition, the Plan may recover from you any benefits paid directly or indirectly based on your material misrepresentation.

Initial Enrollment Period. The "Initial Enrollment Period" for a component benefit is the 30-day period or the enrollment period, if applicable, that begins on the date you first become eligible to participate in that component benefit. If you do not enroll yourself and, if applicable, your eligible dependents in a component benefit when first eligible (during the Initial Enrollment Period) you will be considered a late enrollee and will not be permitted to participate in that component benefit, unless you enroll during an Annual Enrollment Period or pursuant to the applicable Special Enrollment provisions described below.

Special Enrollment (group health plans only).

HIPAA Special Enrollment – Loss of Other Coverage. In addition to the rules below regarding mid-year election changes, if you or certain of your dependents have lost other medical coverage, you may have the opportunity to elect coverage under the applicable group health plan.

In the case of loss of other coverage, Special Enrollment is available to an otherwise eligible employee and, if applicable, his or her eligible dependents who meet each of the following conditions:

- You or your eligible dependent were covered under a group health plan or had health insurance coverage at the time coverage under the applicable plan was previously offered.
- You stated in writing, on behalf of yourself or your eligible dependent, at the time coverage was previously offered, that the other coverage was the reason for declining enrollment. The Plan Administrator must have requested the statement at that time and provided you with notice of this requirement (and its consequences).
- Your prior coverage was
    - COBRA continuation coverage which was exhausted; or
    - non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), employer contributions towards such coverage were terminated, or you reached the lifetime maximum benefit limit for all benefits under the prior plan.

- You request Special Enrollment no later than 30 days following the loss of the other coverage and complete the applicable online enrollment no later than 15 days following your request. Coverage under Special Enrollment as described above will be effective no later than the first day of the month after you request Special Enrollment.

If the Plan Administrator receives a request for Special Enrollment more than 30 days after the loss of the other coverage, or the online enrollment to add an eligible individual due to a loss of coverage is not completed as described above, coverage under Special Enrollment will not be provided. Instead, the next opportunity to enroll will be during the next Annual Enrollment Period or a subsequent Special Enrollment event, if sooner.

Special Enrollment as described above is not available if the other coverage is lost due to the failure to pay the applicable premium or for fraud or misrepresentation. Your eligible dependent may enroll under Special Enrollment described above if the dependent lost such other coverage and you are currently enrolled in the applicable plan. In addition, both you and the dependent can enroll together if either you or the dependent loses such other coverage.

HIPAA Special Enrollment – Newly Acquired Dependents. Special Enrollment is also available when you acquire a new eligible dependent through marriage, birth, or adoption or placement for adoption. Your request to enroll the new dependent must be made no later than 30 days following the date the new dependent is acquired ("qualifying event") and you must complete the online enrollment within the 30 day enrollment period.

If you have previously declined to enroll, you may enroll yourself and your eligible dependents when you marry, or acquire a new child as a result of birth, adoption or placement for adoption.

Coverage under this Special Enrollment provision for newly acquired dependents with respect to marriage will be effective on the date of marriage, provided the online enrollment is completed within the time period described above. In the case of a new child acquired as a result of birth, adoption or placement for adoption, coverage requested timely shall become effective on the date of birth, adoption or placement for adoption.

Enrollment Due to Medicaid/CHIP Events. Eligible employees and their eligible dependents are allowed to enroll for group health plan mid-year coverage if:

- Their coverage is lost under their respective state Medicaid or child health insurance plan (CHIP) or
- They become eligible for premium assistance under their respective state Medicaid or CHIP.

If you are not already enrolled when one of the above events occurs, you will be able to enroll yourself and your eligible dependent(s) within 60 days of the date of the event. Coverage will be effective retroactive to the date of the loss of Medicaid or CHIP coverage or the date you become eligible for premium assistance under Medicaid or CHIP, as applicable.

Enrollment requests received later than the 60 days after one of the above events will not be accepted. However, you will have an opportunity to enroll during the next annual open enrollment period.

Appendix – Special Information Applying to the Benefits described in this booklet

■ *Changing Your Elections*

Because of the tax advantages gained from paying for certain coverage on a before-tax basis, you are generally not permitted to make a change in your coverage election. The Internal Revenue Service, however, allows you to change your enrollment decisions after the Initial Enrollment Period and between Annual Open Enrollment Periods only under certain circumstances.

Thus, once you enroll, your coverage election is irrevocable and remains in effect until the next Annual Open Enrollment Period unless you experience a change in your family or work status, certain changes in cost or coverage under a plan, a Special Enrollment event, or certain other events ("qualifying events"). A complete description of the circumstances under which you may change your coverage elections is contained in the Pace Cafeteria Plan, which is incorporated herein by reference. The discussion that follows highlights these circumstances.

In order to make a change in your prior election under this section, you must complete the online enrollment no later than 30 days following the qualifying event. Your requested change in coverage will go into effect the date of the qualifying event if the online enrollment is completed within the 30 day enrollment period. If the online enrollment is not completed within 30 days following the qualifying event, you must wait until the next Annual Enrollment Period to make any changes, unless otherwise permitted under the Plan.

Family or Work Status Change. If you have a change in your family or work status, you are allowed to make certain changes to your coverage provided they are consistent with your change in family status. To do so, you must complete the online enrollment. The Plan Administrator can help you with what benefit changes are allowed under the component benefit plans and will have the final say on what changes are made.

Qualifying changes in family or work status include but are not limited to:

- marriage, legal separation, divorce, or establishment or termination of domestic partnership;
- the death of your spouse or a dependent;
- the birth or adoption of your child;
- your spouse's employment or termination of employment;
- a change in your, or your spouse's employment status from part-time to full-time employment, or vice versa;
- an unpaid leave of absence taken by you or your spouse; or
- moving to another area.

Changes in Hours of Service. If you are covered under the medical plan during a stability period and experience a reduction in your hours of service, you may revoke your medical plan coverage election if the following two (2) requirements are satisfied: (i) you have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in that status so that you will reasonably be expected to average less than 30 hours of service per week after the change, regardless of the effect of the change on medical plan eligibility; and (ii) your election to revoke medical plan coverage corresponds to your intent to enroll yourself and your then-covered family members in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the

date you revoke coverage under the medical plan. This section applies only to your election with respect to medical plan coverage and not any other component benefit under the Plan.

Changes in Cost of Coverage. You may prospectively change or revoke your prior election during the plan year if the Plan Administrator determines that the election change or revocation is on account of and consistent with a change in the cost of coverage. No change may be made under this subsection during the Plan Year with respect to the component benefit providing health care flexible spending benefits.

In cases where the change in cost for coverage is insignificant, the Plan Administrator will automatically make a prospective increase (or decrease) in your elective contributions for coverage under the applicable component benefit plan. Where the cost change is significant, you may make a corresponding change in your prior election, in accordance with the following guidelines:

- Changes that may be made include (i) commencing participation in a particular benefit option in the case of a decrease in cost for coverage under that option, or, (ii) in the case of an increase in cost, revoking an election for the now more expensive coverage and either receiving on a prospective basis coverage under another benefit option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available.
- A “cost increase or decrease” refers to an increase or decrease in the amount of the elective contributions under a plan, whether that increase or decrease results from an action taken by you (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of employees).
- The election change must be consistent with the change in cost.

Changes in Coverage. You may prospectively change or revoke your prior election during the plan year if the Plan Administrator determines that the election change or revocation is on account of and consistent with a change in coverage. No change may be made under this subsection during the Plan Year with respect to the component benefit providing health care flexible spending benefits.

Where the coverage change is significant, you may make a corresponding change in your prior election, in accordance with the following guidelines:

- If you or your covered dependent have a significant curtailment in coverage during a plan year that is not a loss of coverage described below (e.g., there is a significant increase in the deductible, the required copayments, or the out-of pocket cost sharing limit under a group health plan), you may revoke your election for that coverage and, instead, elect to receive on a prospective basis coverage under another benefit option providing similar coverage. For this purpose, coverage is “significantly curtailed” only if there is an overall reduction in coverage so as to constitute reduced coverage generally.
- If you or your dependent has a loss of coverage with respect to a particular benefit, you may revoke your election and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit option providing similar coverage or to drop coverage if no similar benefit option is available.
- A “loss of coverage” means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefit option, an HMO

ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). A loss of coverage includes (a) a substantial decrease in the medical care providers available under the option; (b) a reduction in the benefits for a specific type of medical condition or treatment with respect to which you or your dependent is currently in a course of treatment; or (c) any other similar fundamental loss of coverage.

- If a plan adds a new benefit option or other coverage option, or if coverage under an existing benefit or other coverage option is significantly improved during a period of coverage, you may revoke your election under the plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit option.

■ ***When Coverage Terminates***

Except as otherwise provided in the applicable benefit booklet, insurance policy or certificate of insurance of a component benefit plan, and unless your coverage is continued or converted as described below, coverage for you and/or your covered dependents will end automatically at midnight of

- the date that the Plan or a component benefit plan is terminated,
- the last day of the month in which you or your dependents no longer satisfy the applicable eligibility requirements for coverage under the applicable component benefit plan,
- the date that you fail to make the required contributions for coverage under the applicable component benefit plan, or
- the date that your current coverage election is no longer in effect.

Important: If you engage in fraudulent conduct or furnish the Organization, Plan Administrator, Claims Administrator or other service provider fraudulent or misleading material information relating to your eligibility for benefits, claims or application for benefits, or other matter regarding your coverage or benefits under the Plan, the Organization may terminate your benefits. Termination is effective on the date you engaged in fraudulent conduct or furnished fraudulent or misleading material information, whichever is applicable. You shall be responsible to pay the Organization for the cost of previously received benefits, less any copayments made or fees paid for such services. If your coverage is terminated, the Organization will also terminate your dependent's coverage, effective on the date your coverage was terminated.

If you permit the use of your or any other person's insurance identification card by any other person, use another person's card, or use an invalid card to obtain benefits under any component benefit plan, your coverage shall terminate immediately. Any person or dependent involved in the misuse of an identification card will be liable to and must reimburse the Organization.

If coverage for you and/or your dependents terminates, you may be eligible to convert your coverage to an individual policy with the applicable insurance carrier. See the applicable benefit booklet, insurance policy or certificate of insurance for more information about these rights, including the time frames for requesting and paying for a conversion policy.

Appendix – Special Information Applying to the Benefits described in this booklet

■ Leaves of Absence

Coverage under a component benefit plan referred to in this booklet will not terminate on account of certain leaves of absence, as described below:

Family and Medical Leave Act.

Notwithstanding any other provision of this Plan, if you take a leave of absence under the Family and Medical Leave Act (FMLA), you and your covered dependents shall continue to participate and be eligible for coverage under medical, dental, vision, long term disability, supplemental life insurance, spousal life insurance and/or supplemental accidental death and dismemberment insurance plan(s) that are component benefit plans in which you were enrolled at the time your leave commenced, in accordance with FMLA, its implementing regulations and the terms of the applicable component benefit plan. Your coverage will continue provided you continue to pay any required employee-portion of the cost of such coverage. If you wish to discontinue your benefit(s), please contact your HR Manager for details. When you return from the FMLA leave, your coverage under the component benefit plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

Employer Contributions. While you are on an FMLA leave, the Organization shall continue to make the same contributions to the applicable component benefit plan(s) on behalf of you and your covered dependents that it would have made had you not taken such leave of absence. The Organization shall continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control either to your immediate supervisor or to any member of your Organization's human resources team.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the Organization shall have the right to be reimbursed by you for any and all contributions the Organization has made on behalf of you and your covered dependents during the leave. In this regard, the Organization shall have the right to obtain reimbursement from any funds that the Organization might otherwise owe you following the your voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued vacation pay or sick leave pay; or (c) other sources. In addition, the Organization shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, the Organization shall be entitled to recover from you any required employee contributions the Organization has made on behalf of you and your covered dependents during an unpaid FMLA leave to ensure continuity of coverage.

The Organization may not recover any of its regular contributions made on behalf of you and your covered dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to an FMLA leave; or (b) other circumstances beyond your control (as set forth in the Employer's FMLA policies and procedures).

Appendix – Special Information Applying to the Benefits described in this booklet

Participant Contributions. As soon as administratively feasible after you qualify for an FMLA leave, the Plan Administrator shall give you the opportunity to choose in writing between continued coverage during the leave of absence, or of suspending coverage for the leave's duration. If you choose ongoing coverage, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect. The written election form given to you must reflect that if you elect to continue active participation, you will be able to make these payments in any combination of the following methods at your option:

- Advance withholding from your last paycheck before any unpaid FMLA leave takes effect;

- Withholding from any salary continuation check for a paid leave of absence that is considered as part of your FMLA leave;

- Monthly payment by you to the Organization from your own funds either at the same time as it would be made if by payroll deduction or on the same schedule as payments are made for COBRA continuation coverage;

- By any other method mutually agreeable to you and the Organization, including (where the leave is foreseeable) increased withholding from one or more of your regular paychecks preceding the leave to pay in advance the required premiums during the leave.

The obligation to provide ongoing coverage under this Plan for you and your covered dependents on an FMLA leave ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the Organization may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event, the Organization's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

Please note that, except in the case of an FMLA leave, the extension of coverage provisions for certain leaves of absence set forth above do not change the date that a continuation coverage period under COBRA would otherwise begin. For example, assume, under the provisions above, coverage under the health plan is extended during a 4 week approved non-FMLA leave of absence. If following that leave period you decide not to return active employment with the Employer and instead choose to elect COBRA continuation coverage, your maximum COBRA continuation period would begin on the date of your reduction in hours of employment (i.e., when you took the leave of absence), not the day after the end of the 4-week leave period. NOTE, however, this is not the case with respect to FMLA leave. In the case of an FMLA leave, the maximum COBRA continuation coverage period, if such coverage is elected, generally begins on the day after the date you fail to return to work following the applicable FMLA leave period.

Uniformed Services Employment and Reemployment Rights Act (applies to component benefit plans offering group health plan coverage only)

The Organization will grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). In general,

during such a leave of absence under USERRA, you and your covered dependents shall continue to participate and be eligible for coverage under medical, dental, vision component benefits (for up to 24 months) that are component benefit plans in which you were enrolled at the time your leave commenced.

Your coverage will continue provided you continue to pay any required employee-portion of the cost of such coverage. The component benefit plans can be continued at the associate rate for the first 12 months. If Associates on Military leave wish to continue for another 12 months, they will be responsible for 102% of the premium. Employees on Military leave are offered COBRA after they have been out on leave for 24 months. If you wish to discontinue your benefit(s), please contact Human Resources for details. When you return from the Military leave, your coverage under the component benefit plan will immediately resume regardless of whether you elected to continue coverage during the Military leave.

More specifically, if you are absent from work for more than 31 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see above, as of the first day of your absence for such duty. This means that you will become eligible to elect continuation coverage under procedures similar to those required by COBRA. The Plan Administrator shall furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your rights to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on your behalf, unless the period of coverage is fewer than 31 days. If you do not make your election within 60 days of being provided with the notice mentioned above you will no longer be eligible to continue coverage under the Organization's group health plans, except as required by USERRA.

The period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, your health coverage and that of your eligible dependents (if any) will be reinstated under the applicable component benefit plans. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Contact the Organization for more information regarding your rights under USERRA to continue coverage under the group health plans that are component benefit plans, as well as reemployment and other rights under USERRA.

Appendix – Special Information Applying to the Benefits described in this booklet

Coverage may be continued in connection with other leaves of absence (e.g., maternity leave, unpaid personal leave, workers' compensation, short term disability and long term disability). For more information contact the Plan Administrator.

APPENDIX -- COBRA Continuation Coverage

■ In General

It is important that all covered individuals take the time to read this information carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide the covered dependent's name and address to the Human Resources Department so a notice can be sent to him or her as well.

Under federal COBRA law, most employers are required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This section is intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under the Continuation Coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, the Plan Administrator will send you additional information and the appropriate election notice at that time. If the component group health plans provide coverage for domestic partners or civil union partners, COBRA Continuation Coverage will be provided to such individuals to the same extent provided in the applicable insurance certificate or benefit booklet.

■ Qualifying Events

Qualifying Events for Covered Employee – If you are the covered employee, you may have the right to elect COBRA Continuation Coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events for Covered Spouse – If you are the covered spouse of a covered employee, you may have the right to elect COBRA Continuation Coverage for yourself if you lose group health coverage under your spouse's employer's group health plan(s) because of any of the following reasons:

- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your spouse.
- Divorce or, if applicable, legal separation from your spouse.
- Your spouse becomes entitled to Medicare.

Qualifying Events for Covered Dependent Children – If you are the covered dependent child of a covered employee, you may have the right to elect Continuation Coverage for yourself if

you lose group health coverage under your parent's group health plan because of any of the following reasons:

- A termination of your parent's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your parent (the covered employee).
- Your parents divorce or, if applicable, legally separate.
- Your parent (the covered employee) becomes entitled to Medicare.
- You cease to be a covered dependent under the terms of the Plan.

Important – *Required Employee, Spouse, and Dependent Notifications*. Under the law, covered individuals, including the employee, spouse, or other family member, have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status, including second qualifying events. This notification must be mailed or hand delivered to the Plan Administrator within 60 days after the later of the date on which the qualifying event occurs or the date on which a qualified beneficiary loses or would lose coverage as a result of the qualifying event. This notice must identify: (i) qualified beneficiaries and their respective addresses and dates of birth, (ii) the qualifying event, (iii) the date it occurred, and (iv) include documentation supporting the occurrence of the qualifying event acceptable to the Plan Administrator. For example, in the case of a divorce, the notice should include a copy of the final divorce decree issued by the court.

If notification is not completed according to the Plan Administrator's procedures and submitted within the required 60-day notification period, then rights to Continuation Coverage will be forfeited. Carefully read the dependent eligibility rules for the particular benefit so you are familiar with when a dependent ceases to be a covered dependent under the terms of the applicable benefit.

■ Electing COBRA Coverage

Election Period and Coverage. Once the Plan Administrator learns a qualifying event has occurred, the COBRA Administrator will notify covered individuals (also known as qualified beneficiaries) of their rights to elect Continuation Coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect Continuation Coverage. The 60-day election window is measured from the later of the date of COBRA notification on or after the qualifying event or the date coverage is lost. This is the maximum period allowed to elect COBRA. If a qualified beneficiary does not elect Continuation Coverage within this election period, then rights to continue coverage under the applicable Plan will end and he or she ceases to be a qualified beneficiary.

To elect Continuation Coverage, you must complete the applicable election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect Continuation Coverage. For example, the covered employee's spouse may elect Continuation Coverage even if the covered employee does not. Continuation Coverage may be elected for only one, several, or for all covered dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any covered dependent children. The covered employee or his or her spouse can elect Continuation Coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

If, during the election period, a qualified beneficiary waives Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of Continuation Coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date that they are sent to the Plan Administrator, or its designee for COBRA administration.

■ Length of Continuation Coverage

18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Extension for Social Security Disability. The 18-month coverage period described above may be extended for 11 months if you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. To receive this extension, you must notify the Plan Administrator of the disability determination within 60 days after the latest of the following events: (i) the date of the Social Security Administration's disability determination; (ii) the date on which the qualifying event occurs; or (iii) the date coverage is or would be lost as a result of the qualifying event; provided the notice is not made later than your initial 18-month period of Continuation Coverage. You must provide this notice by mail or personal delivery to the Plan Administrator. The Plan Administrator requires a special form for providing this notice, which is available from the Human Resources Department free of charge. This notice must (i) identify the qualified beneficiaries and their respective addresses and dates of birth, (ii) certify that the qualified beneficiary continues to be disabled as described under the Social Security Administration's determination, and (iii) include a copy of the Social Security Administration's determination described above.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension.

Note, it is also the qualified beneficiaries' responsibility to notify the Plan Administrator within 30 days if a final determination has been made that they are no longer disabled. In this case, you are required to notify the Plan Administrator of this change in disability status in the manner described above.

Extension for Second Qualifying Events. Another extension of the 18-month or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of Continuation Coverage, a second qualifying event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a covered dependent). If a second qualifying event occurs, then the original 18 or 29 months of Continuation Coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second qualifying event occurs, it is the qualified beneficiaries' responsibility to notify the Plan Administrator or its designee in writing by mail or personal delivery within 60 days of the second event and within the original 18 or 29-month COBRA timeline. This notice must be provided in the manner described in the "Qualifying Events" section above.

If a covered employee becomes entitled to Medicare before experiencing a qualifying event that is a termination of employment or reduction in hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of (i) 36 months after the date the covered employee becomes entitled to Medicare; or (ii) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction in hours of employment.

In no event, however, will Continuation Coverage last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for Continuation Coverage. A reduction in hours followed by a termination in employment is not considered a second qualifying event for COBRA purposes.

36 Months. If the original event causing the loss of coverage was the death of the covered employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a covered dependent child under the Plan, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

■ Coverage Options, Cost, and Timing of Payments

An Employer is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA covered individuals. Should coverage change or be modified for non-COBRA covered individuals, then the change and/or modification will be made to your coverage as well.

If a qualified beneficiary elects Continuation Coverage, he or she will be required to pay the entire cost for the coverage, plus a 2% administration fee. Note that the cost for Continuation Coverage provided during the disability extension described above is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at 102% level.

If you elect Continuation Coverage, you must make your first payment for Continuation Coverage not later than 45 days after the date of your election. If you fail to make your first payment for Continuation Coverage in full before the end of the 45-day period following the

date of your election (which must include all of the premiums that have accrued to the date of payment), you will lose all Continuation Coverage rights under the particular benefit and COBRA.

After you make your first payment for Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period. Each of these periodic payments for Continuation Coverage is due on the first day of the coverage period. However, 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 as long as payment for that coverage period is made before the end of the grace period for that payment.

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. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to Continuation Coverage under the Plan and COBRA.

■ Eligibility and Potential Conversion Rights

A qualified beneficiary does not have to show he or she is insurable to elect Continuation Coverage, however, he or she must have been actually covered by the particular benefit on the day before the qualifying event to be eligible for Continuation Coverage. An exception to this rule is if while on Continuation Coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the Plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in applicable Plan document and must be followed. The Plan Administrator reserves the right to verify COBRA eligibility status and terminate Continuation Coverage retroactively if you are determined to be ineligible or if there has been an intentional misrepresentation of the facts.

At the end of the 18, 29, or 36 months of Continuation Coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under the group health plan if an individual conversion plan is available at that time.

Special rules for employees eligible for trade adjustment assistance. The Trade Act of 2002 created a new tax credit for certain eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. In addition, these employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their Plan coverage ended. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY

callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

■ Early Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end prior to the maximum continuation period for any of the following reasons:

- The Employer ceases to provide any group health plan to any of its employees.
- Any required premium for Continuation Coverage is not paid in a timely manner.
- A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.
- A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare.
- A qualified beneficiary extended Continuation Coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled.
- A qualified beneficiary notifies the Plan Administrator he or she wishes to cancel COBRA Continuation Coverage.
- For cause, on the same basis that the Plan terminates the coverage of similarly situated non-COBRA participants.

Notification of Address Change. To ensure all covered individuals receive information properly and efficiently, it is important that you notify the Plan Administrator of any address change as soon as possible. Your failure to do so may result in delayed COBRA notifications or a loss of Continuation Coverage options.

■ Any Questions?

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your actual COBRA rights at that time. If any covered individual does not understand any part of this summary notice, or has questions regarding the information or his obligations, please contact the Plan Administrator.

In addition, for more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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.).

APPENDIX – Rules Regarding Use and Disclosure of Protected Health Information

■ Use and Disclosure of Protected Health Information

The Plan will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

■ Use and Disclose PHI as Permitted by Authorization of the Participant or Beneficiary

As soon as practicable following the receipt of an authorization from a participant or his or her duly appointed personal representative, the Plan will disclose PHI in accordance with the authorization.

■ Disclosure to the Organization

Upon request of the Organization, the Plan will disclose summary health information and enrollment and disenrollment information to the Organization as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Plan will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the Organization only upon receipt of a certification from the Organization that the applicable Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this Appendix.

To receive PHI as described in the preceding paragraph, the Organization shall certify to the Plan that it agrees to

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Organization creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents, including a subcontractor, to whom the Organization provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Organization with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Organization unless authorized by an individual;
- report to the Plan (i) any security incident as defined under the HIPAA Security Rule, and (ii) any Breach of Unsecured Protected Health Information; provided, however, that to avoid unnecessary burden on either party, the Organization shall report to the

Plan any unsuccessful security incidents of which it becomes aware of only upon request of the Plan. The frequency, content and the format of the report of unsuccessful security incidents shall be mutually agreed upon by the parties. The term "unsuccessful security incidents" mean security incidents that do not result in unauthorized access, use, disclosure, modification or destruction of electronic PHI;

- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Organization still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

■ **Adequate Separation Between the Plan and the Organization Must Be Maintained**

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- Privacy Officer.
- Designated members of the Human Resources, Benefits, Payroll and Accounting Departments.
- Designee(s) of the Privacy Officer.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the Organization shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

APPENDIX – Required Notices

■ Women's Health and Cancer Rights Act of 1998 (Medical Component Benefit Only)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, contact Human Resources at **412-244-1900.**

■ Newborns' and Mothers' Health Protection Act of 1996 (Medical Component Benefit Only)

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

■ Michelle's Law

Please note that the Plan does comply with Michelle's Law, however due to Health Care Reform, the Plan does not require children to be students and would not lose benefit eligibility under the Plan if they lost student status for any reason. Eligible children are covered until the end of the month in which they turn 26.

Michelle's Law applies to group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the Organization's group health plan as a student but lose their student status because they take a medically necessary leave of absence from Organization.

As a result, if your child is no longer a student, as defined in the Plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under

the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the Plan would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child’s treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination With COBRA Continuation Coverage. If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions? If you have any questions regarding the information in this notice or your child’s right to Michelle’s Law’s continued coverage, or if you would like a copy of your Summary Plan Description, you should contact Human Resources at 412-244-1900.

■ Patient Protection Disclosure

To the extent the medical or prescription benefit component plans require or allow for the designation of primary care providers by participants or beneficiaries,

- participants have the right to designate any primary care provider who participates in the network and who is available to accept the participant and the participant’s covered family members;
- if the component plans require or allow for the designation of a primary care provider for a child, participants may designate a pediatrician as the primary care provider; and

- a participant or beneficiary does not need prior authorization from the component benefit plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the applicable network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier.

4845-4294-2243, v. 3