2022 Plan Year

Greetings from DEK Industrial Services, LLC DBA 360 Industrial Services,

This email contains important information regarding your 2022 benefits.

Kindly review the Benefits Enrollment Guide and other documents.

Please let me know if you have any questions or concerns.

Sincerely,

Aimee Ong

Aimee Ong

Benefits Department

DEK Industrial Services, LLC DBA 360 Industrial Services

benefits@360industrialservices.com

www.360industrialservices.com

2005 W 14th St. Suite 134, Tempe, AZ 85281

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DEK Industrial Services, LLC DBA 360 Industrial Services

2022 BENEFITS

INDEX

- BENEFIT NOTICES

DEK Industrial Services, LLC

(DBA 360 Industrial Services)

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281

This Document includes:

ERISA Summary Plan Document (SPD Wrap)

Section 125 POP Plan

Annual Compliance Notices

Amended and Restated January 01, 2022

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I. SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document and the certificates issued with respect to the Welfare Programs described herein (the "Certificates") together comprise the Summary Plan Description (SPD) for the DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan (the "Plan"). If the terms of this document conflict with the terms of the Certificates, then the terms of the Certificates will control, unless otherwise required by law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan

PLAN SPONSOR:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281

The Plan Sponsor is sometimes referred to as the " ***Company***."

EMPLOYER IDENTIFICATION NUMBER:

46-2752036

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281

TYPE OF PLAN:

DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan including Medical, Health Savings Account (HSA) , Dental, Vision, Life and AD&D, Disability, Critical Illness, Accident and Voluntary Life and AD&D benefits. Not all benefit options are offered to all employees. Benefit options may vary based on employee classification.

PLAN YEAR:

Other than any applicable short plan year, the Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

CLAIMS ADMINISTRATION:

Claims for benefits are administered by the respective companies set forth at Appendix A that include but are not limited to: Medical, Health Savings Account (HSA) , Dental, Vision, Life and AD&D, Disability, Critical Illness, Accident and Voluntary Life and AD&D.

AGENT FOR SERVICE OF LEGAL PROCESS:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281

You may also serve legal process on the Plan Administrator or any successor in title or office of the current registered agent of the company.

TYPE OF ADMINISTRATION:

Benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies.

ELIGIBILITY:

The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document. Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the eligibility and/or participation requirements stated in this SPD and the Plan Document shall control, as otherwise set forth below:

You will be eligible to participate in the Plan if you are a full-time employee regularly scheduled to work at least 30 hours per week ("full-time Employee").

Other individuals, such as an Eligible Employee's spouse, children, or other designated member, may be eligible to participate in and receive benefits under one or more of the Welfare Programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the applicable Policy or Welfare Program Documents.

You will enter the plan on the first day of the month.

A reemployed former Participant shall again be eligible to become a Participant in the Plan when the Participant again satisfies the requirements set forth in the Section titled: "Eligibility and Participation".

AMENDMENT AND TERMINATION:

The DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan (the "Plan Document") contains all the terms of the Plan and may be amended from time to time at its sole discretion by your Employer. Any changes made shall be binding on each Covered Participant and any other Covered Persons referred to in the Plan Document.

The Booklet will disclose any Plan provisions governing your benefits, rights and obligations upon plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under policies of insurance as listed in Appendix A that include but are not limited to: Medical, Health Savings Account (HSA) , Dental, Vision, Life and AD&D, Disability, Critical Illness, Accident and Voluntary Life and AD&D. These Welfare Programs are insured or administered by the companies also listed in Appendix A and are generally described in the Plan Document. The administrative functions include paying claims and determining medical necessity replacement for lost or misplaced copies of the Plan Document may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

- Not all benefit options are offered to all employees. Benefit options may vary based on employee classification.

Please refer to the Plan Document for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

II. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages summarized in Appendix A. A summary of the benefits provided under the Plan is set forth in the certificates issued by the insurance companies.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION 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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

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:

1. All stages of reconstruction of the breast upon which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Welfare Benefit Booklet.

CONTRIBUTIONS:

Contributions to the Plan are provided by the Employer and Employees. Employee contributions are made via automatic payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the article entitled "CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS" or "CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA" as the case may be.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the appropriate insurance policies and/or summaries of coverage for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventative services are covered under the Plan;
- Whether, and under what circumstances, existing and new drugs are covered under the Plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;

- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

III. CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.*** If the Welfare Program is subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for Plans Subject to PPACA."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

    ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts

whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) 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.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, 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; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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 any such individual;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement

describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, 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 the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant 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 basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator (as defined in the Plan) will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request, specifying what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time, not to exceed 48 hours. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be

provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames:

        1. 72 hours in the case of an urgent care claim;
        2. 30 days in the case of a pre-service claim;
        3. before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment;
        4. 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or
        5. 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis, violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, claims administrator or Named Fiduciary.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement

describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring an action under ERISA Section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

    1. No deference will be afforded to the initial adverse determination;

    2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

    3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

    4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

    5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

    6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

IV. CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.*** If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for PPACA Exempt Plans."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

    ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts

whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) 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.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, 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; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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 any such individual;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement

describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, 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 the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant 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 basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of that fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify the individual within 24 hours after receiving the request specifying what information is needed. The covered person must provide the specified information to the Claims Administrator within a reasonable amount of time not to exceed 48 hours. The Claims Administrator will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be

provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, as required by law, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the appeal procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a

statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office or state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

"Relevant Information" is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

    1. No deference will be afforded to the initial adverse determination;

    2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

    3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

    4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

    5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual;

    6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method; and

    7. The claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

8. **External Claims Procedure.** After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

V. WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your medical coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence or if your employment with the Company ends.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided for a Welfare Program, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. 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. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility for these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding sentence, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a Covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.
3. The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A Covered Employee's enrollment in any part of the Medicare program.
5. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. This plan can charge up to 102% of the total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). 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 Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under “Are there other coverage options?” for more information on your options for Marketplace coverage.

What is the election period and how long must it last?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation

coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for the Employee and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the Employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or
4. the Employee's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing*****.** Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

WEX Health Inc.
4321 20th Avenue S
Fargo, ND 58103

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

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

Once the Plan Administrator or its designee receives timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA 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 COBRA 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 they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

5. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    1. 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

    1. 36 months after the date the Covered Employee becomes entitled to Medicare; or

    2. 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a Covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA

continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan at a later date is also considered Timely Payment if either (i) under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed to make the payment until that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed to pay for coverage of similarly situated non COBRA beneficiaries for the period in question until that later date.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

For more information

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

FAMILY AND MEDICAL LEAVE ACT:

Except to the extent otherwise provided in the appropriate insurance policies and/or summaries of coverage, the provisions provided in this document with respect to the Family and Medical Leave Act of 1993 (FMLA) will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Company’s operations, certain highly paid “key” employees may not be reinstated after FMLA leave.

You must notify your Plan Administrator at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Plan Administrator to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the plan's eligibility requirements). You will be responsible for paying your portion of these benefits at active employee rates while you are on leave. You will be required to pay your contributions for your benefits on a monthly basis (with after-tax dollars) in the manner required by the Company. Please contact your Plan Administrator for more information.

You will be eligible for new benefits that are offered by the Company during your leave. Your coverage will also be affected by any changes that the Company makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a life change event.

FMLA and leave to care for a service member

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave may also be available. Any leave related to military duty or military illness or injury will be administered in accordance with applicable federal requirements.

Caregiver Leave

Caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces service member recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a service member who is medically unfit to perform the duties of his or her office, grade, rank or rating, and the service member is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the service member.

Caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week caregiver leave may only be taken in a single 12-month period.

Active Duty Leave

If you are eligible for FMLA leave, active duty unpaid leave (when required by the government) will be granted if a family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Company will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in regulations, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Company with notice as soon as it is "reasonable and practicable" and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact your human resources office.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the appropriate insurance policies and/or summaries of coverage, the maximum length of extended coverage under USERRA is the lesser of:

1. 24 months beginning on the date that the military leave begins; or
2. A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might

otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.

VI. QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

VII. SUBROGATION & RIGHT OF REIMBURSEMENT

The provisions of this section pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this section pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan's designee, has a right of recovery.

The Plan's right of recovery includes the right to be reimbursed from any payment by the third party for the covered person's sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person's right of recovery against the third party. The Plan's right of recovery extends to any right of recovery the covered person's estate, spouse, dependents, guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The covered person (and the covered person's personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. The covered person (or the covered person's personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan's right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person's attorneys' fees and costs. Any full or partial recovery by the covered person against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan's right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the covered person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), or any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys' fees and costs from the covered person.

The covered person shall not do anything to hinder the Plan's right of recovery. The covered person shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which the covered person may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to a covered person's injury or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.

VIII. PPACA COMPLIANCE

Pre-Existing Conditions. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. “Essential benefits” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term “Dependent" includes any child of a participant who is covered under an insurance contract, as defined in the contract, as defined in the plan, to the extent allowed by PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Cost Sharing Limits. With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2022, these limits are $8,700 for an individual and $17,400 for family coverage. After 2022, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums for Essential Health Benefits of a group health plan, the Plan will combine with the annual limitation on out-of-pocket maximums between each provider as an aggregate benefit limit amount.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, this Plan will not deny any “qualified individual,” as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, this Plan will not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

IX. ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the 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) if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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 Series) if any, and updated plan document and summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

To the extent applicable under your applicable Welfare Plan options, you may 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, if available. Review this SPD Supplement and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the 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 administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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.

APPENDIX A

SUMMARY OF BENEFIT OPTIONS AND PROVIDER CONTACTS

Welfare Program	Insurance Company or Third Party Administrator	Policy or Contract Number	PPACA Applicability
Health Plan (Fully-Insured) United Healthcare Effective Date: 01/01/2022	United Healthcare 1 East Washington Street, Suite 1700 Phoenix, AZ 85004	06Q5849	Applicable
Health Savings Account (HSA) Optum Bank Effective Date: 01/01/2022	Optum Bank 11000 Optum Circle MN101-EO12 Eden Prairie, MN 55344	Individual	Applicable
Dental United Concordia Effective Date: 01/01/2022	United Concordia 4401 Deer Path Road Harrisburg, PA 17110	005-922234	Applicable
Vision Superior Vision Effective Date: 01/01/2022	Superior Vision 11090 White Rock Rd Suite 175 Rancho Cordova, CA 95670	03826001	Applicable
Group-Term Life *** Mutual of Omaha Effective Date: 01/01/2022	Mutual of Omaha Mutual of Omaha Plaza, PO Box 2476 Omaha, NE 68103	122821	Applicable
Short-Term Disability*** (Fully-Insured) Mutual of Omaha Effective Date: 01/01/2022	Mutual of Omaha Mutual of Omaha Plaza, PO Box 2476 Omaha, NE 68103	122821	Applicable
Critical Illness Mutual of Omaha Effective Date: 01/01/2022	Mutual of Omaha Mutual of Omaha Plaza, PO Box 2476 Omaha, NE 68103	122821	Applicable
Accident Mutual of Omaha Effective Date: 01/01/2022	Mutual of Omaha Mutual of Omaha Plaza, PO Box 2476 Omaha, NE 68103	122821	Applicable
Voluntary Life I AD&D*** Mutual of Omaha Effective Date: 01/01/2022	Mutual of Omaha Mutual of Omaha Plaza, PO Box 2476 Omaha, NE 68103	122821	Applicable

***Not all benefit options are offered to all employees. Benefit options may vary based on employee classification

Important Notice from DEK Industrial Services, LLC (DBA 360 Industrial Services) About Your Prescription Drug Coverage and Medicare

Individual creditable coverage disclosure notice

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with DEK Industrial Services, LLC (DBA 360 Industrial Services) (the "Company") in the DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan (the "Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has been informed that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered "Creditable Coverage". Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage may be affected. If you opt to purchase a Medicare drug plan, the coverage under the drug Plan may no longer be available. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your plan administrator if you have further questions.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 62 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage Contact the Company Office for further information at:

Benefits Department
DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281
602-903-7999
benefits@360industrialservices.com

NOTE: You will receive this notice annually. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender	DEK Industrial Services, LLC (DBA 360 Industrial Services)
Contact / Attention	Benefits Department
Address	2005 W 14th Street Suite 134 Tempe, AZ 85281
Phone Number	602-903-7999
Date	January 01, 2013

Employer Requirements for Medicare Modernization Act

1. Must identify who is Medicare Eligible Individual, including their dependents;
    - Active Medicare eligible Employees or their Medicare eligible dependents
    - Medicare eligible Cobra Participant, or their Medicare eligible dependents
    - Medicare eligible Disabled Individual covered under the RX Plan
    - Medicare eligible Retirees or their dependents who are covered under the RX Plan
2. Determine if Group Health Plan or RX benefit is "Creditable"
3. Provide the disclosure notices to Medicare Eligible individuals (as noted above), at minimum
    - prior to individuals initial enrollment period for Medicare RX drug benefit
    - prior to the effective date of enrolling in the sponsors plan & upon any change that affects whether coverage is creditable RX benefit
    - prior to the commencement of annual election period that begins on 10/15 of each year
    - and upon beneficiary request
4. Complete Online Questionnaire (link below) within 60 days of the beginning of the Plan year or within 30 days of a plan termination or change

    https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by the Company's group health Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor we often need access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below:

DEK Industrial Services, LLC (DBA 360 Industrial Services)

2005 W 14th Street Suite 134
Tempe, AZ 85281

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

Employer Requirements for Distributing ERISA Documents

The Plan Administrator/Employer is responsible for preparing the Summary Plan Description ("SPD") and**AFFIRMATIVELY DELIVERING** it to certain persons:

- Covered Employees
- Terminated Cobra Participants
- Parents or guardians of children covered under a qualified medical support order
- Dependents of a deceased participant
- Guardians of an incapacitated person

An employer should be prepared to prove it furnished the SPD in a way "reasonably calculated to ensure actual receipt" using a method "likely to result in full distribution".

I.E., first class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

Electronic Distribution of ERISA Documents

Employees with work-related computer access

The employee has the ability to access documents at any location where they perform employment duties. Access to Employer’s electronic information system must be an integral part of their normal duties.

- Electronic materials prepared and furnished in accordance with applicable requirements
- Notice is provided to each recipient when furnished, detailing the document
- Notice advises participant of their rights to access the document and how to request a paper copy
- Employer must take steps to ensure the electronic transmittal will result in actual receipt
- If disclosure includes PHI, steps are taken to safeguard the confidentiality of the information

Requirements for Employees with Non-work related computer access or non-employees

May include COBRA participants, dependents or disabled participants.

- Affirmative consent required; Pre-Consent must be obtained, which include details of types of document to be provided, right to withdraw consent, including procedures and updating of information (new email), right to request a paper version and if any cost, and the hardware and software requirements to access the electronic document.
- Pre-Consent statement can be sent electronically if have a reliable e-mail address
- If system hardware or software requirements change, a revised statement must be provided and consent from each individual must be obtained.
- If documents provided on Internet, Consent must be given in a manner that illustrates the individual’s ability to access the information along with a current email address.
- Employer must keep track of individual email addresses for delivery, the consents and actual receipt of emailed documents by recipients.
- These requirements along with the five steps outlined for Employees with work-related computer access above.

ERISA Required Documents for Participants

- SPD - Summary Plan Description
- Restatement of SPD due to Plan Modifications
- SBC - Summary of Benefits and Coverage
- SAR - Summary Annual Report
- Plan Documents

Document	Distribution Instructions
SPD	To Participants within 90 days of coverage on existing plan; within 120 days for new plan. Every 5 years if plan amended or every 10 years if no changes made.
Restatement of SPD	To Participants no later than 210 days after end of the plan year in which change is adopted.
SBC	To participants with enrollment materials, at renewal or reissue of coverage. Special enrollees no later than 90 days from enrollment. Otherwise, within 7 days of written request.
SAR	To participants within 9 months after plan year end if Employer is required to file Form 5500 for the benefit plan.
PLAN DOCUMENT	Copies must be furnished no later than 30 days after written request.

- Other Group Health Plan Notices

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns’ and Mothers’ Health Protection Act (Newborns’ Act), and the Women’s Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in the publication on EBSA’s Website at http://dol.gov/ebsa.

Participant Distribution Receipt

The Plan Administrator should provide a copy of the Summary Plan Description to each participant every year.

The Plan Administrator should have each participant sign a copy of this form and should keep the signed copy in the Plan Administrator’s records.

Plan Name	**DEK Industrial Services, LLC (DBA 360 Industrial Services) Wrap Plan**
Plan Year Start	**January 01**

Participant Signature _____

Participant Name _____

Date _____

DEK Industrial Services, LLC (DBA 360 Industrial Services)

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281

Section 125 Premium Only Plan

Summary Plan Description

Amended and Restated January 01, 2022

INTRODUCTION

The Company's Premium Only Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies or other benefit programs, if self funded. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Premium Only Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found within this SPD

Overview

This section contains general information, which you may need to know about the DEK Industrial Services, LLC (DBA 360 Industrial Services) Premium Only Plan.

General Information

1. The name of the Plan is the DEK Industrial Services, LLC (DBA 360 Industrial Services) Premium Only Plan.
2. The company amends and restates this Plan as of January 01, 2022 with an original effective date of January 01, 2013.
3. This Plan's records are maintained over a twelve-month period. This is known as the Plan Year. The adopted plan year begins on January 01 and ends on December 31.
4. This Plan is unfunded, meaning that the funds to pay Benefits and to otherwise operate the Plan come from the general assets of the Employer and not from a separate trust arrangement or fully-insured insurance arrangement.

Employer Information:

Your Employer's name, address, and tax identification number are:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281
Federal Employer I.D. Number: 46-2752036

Plan Administrator Information:

The name, address, and tax identification number of your Plan's Administrator are:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281
Federal Employer I.D. Number: 46-2752036

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. You may contact the Administrator for any further information about the Plan.

Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

DEK Industrial Services, LLC (DBA 360 Industrial Services)
2005 W 14th Street Suite 134
Tempe, AZ 85281
Federal Employer I.D. Number: 46-2752036

Type of Administration

The type of Plan administration is Employer Administration.

Unless the Plan provides otherwise, the Administrator keeps the records for the Plan and is responsible for the administration and interpretation of the Plan. The Administrator will also answer any questions you may have about the Plan.

01. **How Does This Plan Operate?**

    Before the start of each Plan Year, you will be able to elect to have some of your future salary or other compensation contributed to the Plan in lieu of receiving those amounts in cash, and your future salary or other compensation will be automatically reduced by the amount elected as a contribution to the Plan. The money contributed will be used to pay for benefits you have elected based on the options sponsored by your Employer (and as identified on your "Election to Participate" form). The portion of your pay that is contributed to pay for the benefits provided for under the Plan is not subject to State or Federal income or Social Security taxes. In other words, the Plan allows you to use tax-free dollars to pay for insurance coverage, premium amounts, or other allowable plan contributions or expenses which you normally pay for with out-of-pocket, taxable dollars.

02. **What Happens to Contributions Made to the Plan?**

    Before each Plan Year begins, you will select the benefits or programs you desire to pay for through the Plan with your own pre-tax contributions. Then, during each pay period during that Plan Year, the contributions deducted from your paycheck will be used to pay your portion of your employer-sponsored benefit coverage. Any contribution amounts that are not used during a Plan year to provide insurance benefits will be forfeited and may not be paid to you in cash or used to provide benefits specifically for you in a later Plan year with the exception of HSA contributions that remain available for your use under terms established under your HSA arrangement.

03. **When Is the "Election Period" for Our Plan?**

    Your initial election period will start on the date you first meet the "eligibility requirements" and end 30 days thereafter. Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all participants. It will be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. Your previous elections will be maintained unless a change request is provided to the Plan Administrator by the deadline of the Open Enrollment period.

04. **May I Change My Elections During the Plan Year?**

    Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. For example: you are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

    - Marriage, divorce, death of a spouse, legal separation or annulment;
    - Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
    - Any of the following events for you, your spouse or dependent: commencement or termination of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
    - One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance, including a change to cover adult children who have not attained age 27 as of the end of the taxable year; and
    - A change in the place of residence of you, or your spouse or dependent.
    - A change in your Full-Time status that results in a reduction in work hours that are consistently below an average of 30 hours per week.
    - When you elect to enroll in a qualified health plan in a Martketplace during the Annual Open Enrollment or Special Enrollment Period of that Marketplace.

    There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are separate laws that give you rights to change accident and/or health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

    If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to (i) make corresponding changes in your payments, (ii) revoke your election and obtain coverage under another benefit package option with similar coverage, or (iii) revoke your election entirely.

    If the coverage under a Benefit is significantly curtailed, and such curtailment results in a complete loss of coverage, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, or significantly improve an existing option, you may elect the newly added or improved option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain

situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

A change in compensation or a financial "hardship" is not a reason to change your election amount.

If you have declined enrollment in the Plan for you or your dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program (CHIP), there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if you declined enrollment in the Plan for you or your dependents (including spouse), and later become eligible for state assistance through a Medicaid or Children's Health Insurance Program that provides help with paying for Plan coverage, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

The Plan may permit you to make a prospective election change that is on account of and corresponds with a change made under another employer plan that is a cafeteria plan or a qualified benefits plan if the election for a period of coverage for this Plan is different from the period of coverage (open enrollment) under the other plan.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having had a change in status

5. **May I Make New Elections in Future Plan Years?**

You will not be automatically enrolled in subsequent plan years; enrollment will be communicated each year prior to open enrollment, which means enrollment may or may not be automatic.

6. **What Insurance Coverage May I Purchase?**

Under our Plan, you can choose to receive your entire compensation in taxable compensation or use a portion to pay premiums on a pre-tax basis for any one or more insured benefits that we decide to offer through the Plan. Certain limits may apply on the amount of coverage that we obtain on your behalf. The insurance contracts will normally control.

We may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing the benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after (i) you have provided the Administrator the necessary information to apply for insurance, and (ii) the insurance is in effect for you.

If you cover your children (up to age 26) under your insurance, you can pay for that coverage through the Plan. You may purchase:

- Group Medical Plan
- Group Dental Plan
- Group Vision Plan

07. **Will My Social Security Benefits Be Affected?**

Your Social Security benefits may be slightly reduced, because when you use part of your compensation to pay for insurance premiums on a tax-free basis under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

08. **What if I take a Family or Medical Leave?**

If you take an unpaid leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and you may participate in annual enrollment. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you may reinstate coverage for the remaining portion of the Plan Year upon your return.

Your employer may choose to continue coverage on your behalf during your FMLA leave. Your employer will arrange a schedule for you to "catch up" your payments when you return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage through payroll deduction prior to the start of your leave, provided such payroll deduction is for benefits within the remaining portion of the plan year, or you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

If you take a paid leave under the Family and Medical Leave Act, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the premiums being paid by the method normally used during any paid leave.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

09. **Do Limitations Apply to Highly Compensated Employees?**

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or are highly paid.

If you are within either of these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid key employees, or their spouses or dependents. These provisions are also applicable if your Employer makes Employer contributions through the Plan on your behalf.

Your own circumstances will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

10. **What Happens If I Terminate Employment?**

If you leave our employ during the Plan Year, you will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment. Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to you in cash or used to provide benefits specifically for you in a later Plan Year.

If you are enrolled in a Health Savings Account and are making contributions through the Plan, any unused amounts within your HSA will continue to be available to you for withdrawal to pay qualified expenses on a tax-free basis, or may be distributed to you, subject to applicable IRS guidelines or the terms of your HSA account. You should contact the HSA Trustee to discuss any questions regarding any rights you may have to unused amounts held in your Health Savings Account at termination.

11. **What is a Health Savings Account?**

In addition to the Premium Only Plan benefits, described above, this Plan also may provide for contributions (via payroll deduction) to be made by you on a pre-tax basis to a "Health Savings Account" (also referred to as an "HSA Program"). The HSA is a type of account that enables those who elect to participate in this program to pay eligible HSA Medical Expenses or allow distribution of remaining balances for other qualifying purposes. The HSA Program, if applicable, is separately provided and administered through an HSA Trustee or similar custodial account. Your Employer's election to enable you to make contributions to the HSA Program merely provides the opportunity for you to contribute such amounts through this Plan on a pre-tax basis.

In general, unless otherwise excluded from participation, all Participants in the Premium Only Plan are eligible to receive benefits under the HSA Program. Enrollment and termination under the Premium Only Plan shall generally constitute enrollment and termination of participation under the HSA Program as well. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Premium Only Plan; if your Employer allows you to make contributions through this Plan to your HSA plan; you elect the amount to be withdrawn from your salary in the same manner as otherwise set forth above. Your employer may also elect to contribute employer contribution amounts to your HSA plan, on a discretionary basis, and in accordance with the Plan's general limitations on the allow ability of employer contributions overall (NOTE: You should contact the HSA Trustee for any other questions you may have about eligibility to establish or participate in an HSA, what benefits may be received through participation in such program and how contributed HSA amounts are used to pay for qualifying expenses under the HSA program).

The eligible Employee will establish a Health Savings Account for contributions as elected for the HSA Program established or provided by the HSA Trustee. (NOTE: You should contact the HSA Trustee for more information about the amount you may contribute each year. The HSA Trustee will provide more information to you regarding the requirements for participation in the HSA Program and the benefits you are entitled to thereunder. To the extent of any conflict between the terms of this Plan and those of the HSA Program, the terms of the HSA Program will control.) We are not responsible for the decisions and operations of the HSA Trustee in the administration of the HSA Program.

12. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a Participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

Benefits Notices

DEK Industrial Services, LLC

(dba 360 Industrial Services)

2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999

Created on: 04/07/2022

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Notice of Patient Protections

DEK Industrial Services, LLC (dba 360 Industrial Services) Welfare Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Benefits Department at 2005 W. 14th St. Suite 134, Tempe, Arizona 85281, (602) 903-7999, benefits@360industrialservices.com.

For children, you may designate a pediatrician as the primary care provider.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Benefits Department at 2005 W. 14th St. Suite 134, Tempe, Arizona 85281, (602) 903-7999, benefits@360industrialservices.com.

Notice of Privacy Practices

DEK Industrial Services, LLC (dba 360 Industrial Services)
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999

Privacy Official:

Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

Effective Date: 01/01/2022

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Benefits Department
  2005 W. 14th St. Suite 134
  Tempe, Arizona 85281
  (602) 903-7999
  benefits@360industrialservices.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Noticia de Prácticas de privacidad

DEK Industrial Services, LLC (dba 360 Industrial Services)
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999

Privacy Official:

Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

Fecha de vigencia: 01/01/2022

Su información. Sus derechos. Nuestras responsabilidades.

Esta notificación describe cómo puede utilizarse y divulgarse su información médica, y cómo puede acceder usted a esta información. **Revísela con cuidado.**

Sus derechos

Usted cuenta con los siguientes derechos:

- Obtener una copia de su historial médico y de reclamos.
- Corregir en papel o en formato electrónico su historial médico.
- Solicitar comunicación confidencial.
- Pedirnos que limitemos la información que compartimos.
- Recibir una lista de aquellos con quienes hemos compartido su información.
- Obtener una copia de esta notificación de privacidad.
- Elegir a alguien que actúe en su nombre.
- Presentar una queja si considera que se violaron sus derechos de privacidad.

Sus opciones

Tiene algunas opciones con respecto a la manera en que utilizamos y compartimos información cuando:

- Respondemos las preguntas de cobertura de su familia y amigos.
- Proporcionamos alivio en caso de una catástrofe.
- Comercializamos nuestros servicios y vendemos su información.

Nuestros usos y divulgaciones

Podemos utilizar y compartir su información cuando:

- Ayudamos a administrar el tratamiento de atención médica que usted recibe.
- Dirigimos nuestra organización.
- Pagamos por sus servicios médicos.
- Administramos su plan médico.
- Ayudamos con asuntos de seguridad y salud pública.
- Realizamos investigaciones médicas.
- Cumplimos con la ley.
- Respondemos a las solicitudes de donación de órganos y tejidos y trabajamos con un médico forense o director funerario.
- Tratamos la compensación de trabajadores, el cumplimiento de la ley y otras solicitudes gubernamentales.
- Respondemos a demandas y acciones legales.

Sus derechos

Cuando se trata de su información médica, usted tiene ciertos derechos. Esta sección explica sus derechos y algunas de nuestras responsabilidades para ayudarlo.

Recibir una copia de su historial médico y de reclamos

- Puede solicitar que le muestren o le entreguen una copia de su historial médico y reclamos y otra información médica que tengamos de usted. Pregúntenos cómo hacerlo.
- Le entregaremos una copia o un resumen de su historial médico y de reclamos, generalmente dentro de 30 días de su solicitud. Podemos cobrar un cargo razonable en base al costo.

Solicitarnos que corrijamos el historial médico y de reclamos

- Puede solicitarnos que corrijamos su historial médico y de reclamos si piensa que dichos historiales son incorrectos o están incompletos. Pregúntenos cómo hacerlo.
- Podemos decir "no" a su solicitud, pero le daremos una razón por escrito dentro de 60 días.

Solicitar comunicaciones confidenciales

- Puede solicitarnos que nos comuniquemos con usted de una manera específica (por ejemplo, por teléfono particular o laboral) o que enviemos la correspondencia a una dirección diferente.
- Consideraremos todas las solicitudes razonables y debemos decir "sí" si nos dice que estaría en peligro si no lo hacemos.

Solicitarnos que limitemos lo que utilizamos o compartimos

- Puede solicitarnos que no utilicemos ni compartamos determinada información médica para el tratamiento, pago o para nuestras operaciones.
- No estamos obligados a aceptar su solicitud, y podemos decir "no" si esto afectara su atención.

Recibir una lista de aquellos con quienes hemos compartido información

- Puede solicitar una lista (informe) de las veces que hemos compartido su información médica durante los seis años previos a la fecha de su solicitud, con quién la hemos compartido y por qué.
- Incluiremos todas las divulgaciones excepto aquellas sobre el tratamiento, pago y operaciones de atención médica, y otras divulgaciones determinadas (como cualquiera de las que usted nos haya solicitado hacer). Le proporcionaremos un informe gratis por año pero cobraremos un cargo razonable en base al costo si usted solicita otro dentro de los 12 meses.

Obtener una copia de esta notificación de privacidad

- Puede solicitar una copia en papel de esta notificación en cualquier momento, incluso si acordó recibir la notificación de forma electrónica. Le proporcionaremos una copia en papel de inmediato.

Elegir a alguien para que actúe en su nombre

- Si usted le ha otorgado a alguien la representación médica o si alguien es su tutor legal, aquella persona puede ejercer sus derechos y tomar decisiones sobre su información médica.
- Nos aseguraremos de que la persona tenga esta autoridad y pueda actuar en su nombre antes de tomar cualquier medida.

Presentar una queja si considera que se violaron sus derechos

- Si cree que hemos violado sus derechos, haganoslo saber en :
  Benefits Department
  2005 W. 14th St. Suite 134
  Tempe, Arizona 85281
  (602) 903-7999
  benefits@360industrialservices.com
- Puede presentar una queja en la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos enviando una carta a: Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, llamando al 1-800-368-1019 o visitando **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html**, los últimos dos disponibles en español.
- No tomaremos represalias en su contra por la presentación de una queja.

Sus opciones

Para determinada información médica, puede decirnos sus decisiones sobre qué compartimos. Si tiene una preferencia clara de cómo compartimos su información en las situaciones descritas debajo, comuníquese con nosotros. Díganos qué quiere que hagamos, y seguiremos sus instrucciones.

En estos casos, tiene tanto el derecho como la opción de pedirnos que:

- Compartamos información con su familia, amigos cercanos u otras personas involucradas en el pago de su atención.
- Compartamos información en una situación de alivio en caso de una catástrofe.

Si no puede decirnos su preferencia, por ejemplo, si se encuentra inconsciente, podemos seguir adelante y compartir su información si creemos que es para beneficio propio. También podemos compartir su información cuando sea necesario para reducir una amenaza grave e inminente a la salud o seguridad.

En estos casos, nunca compartiremos su información a menos que nos entregue un permiso por escrito:

- Propósitos de mercadeo.
- Venta de su información.

Nuestros usos y divulgaciones

Por lo general, ¿cómo utilizamos o compartimos su información médica? Por lo general, utilizamos o compartimos su información médica de las siguientes maneras.

Ayudar a administrar el tratamiento de atención médica que usted recibe

- Podemos utilizar su información médica y compartirla con otros profesionales que lo estén tratando.

Ejemplo: Un médico nos envía información sobre su diagnóstico y plan de tratamiento para que podamos organizar los servicios adicionales.

Dirigir nuestra organización

- Podemos utilizar y divulgar su información para dirigir nuestra organización y comunicarnos con usted cuando sea necesario.
- **No se nos permite utilizar información genética para decidir si le proveemos cobertura y el precio de dicha cobertura.** Esto no se aplica a los planes de atención a largo plazo.

Ejemplo: Utilizamos su información médica para ofrecerle mejores servicios.

Pagar por sus servicios medicos

- Podemos utilizar y divulgar su información médica cuando pagamos por sus servicios médicos.

Ejemplo: Compartimos su información con su plan dental para coordinar el pago por su trabajo dental.

Administrar su plan

- Podemos divulgar su información médica a su patrocinador del plan médico para la administración del plan.

Ejemplo: Su compañía nos contrata para proveer un plan médico, y nosotros le proporcionamos a su compañía determinadas estadísticas para explicar las primas que cobramos.

¿De qué otra manera podemos utilizar o compartir su información médica? Se nos permite o exige compartir su información de otras maneras (por lo general, de maneras que contribuyan al bien público, como la salud pública e investigaciones médicas). Tenemos que reunir muchas condiciones legales antes de poder compartir su información con dichos propósitos. Para más información, visite: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html**, disponible en español.

Ayudar con asuntos de salud pública y seguridad

- Podemos compartir su información médica en determinadas situaciones, como:
- Prevención de enfermedades.
- Ayuda con el retiro de productos del mercado.
- Informe de reacciones adversas a los medicamentos.
- Informe de sospecha de abuso, negligencia o violencia doméstica.
- Prevención o reducción de amenaza grave hacia la salud o seguridad de alguien.

Realizar investigaciones médicas

- Podemos utilizar o compartir su información para investigación de salud.

Cumplir con la ley

- Podemos compartir su información si las leyes federales o estatales lo requieren, incluyendo compartir la información con el Departamento de Salud y Servicios Humanos si éste quiere comprobar que cumplimos con la Ley de Privacidad Federal.

Responder a las solicitudes de donación de órganos y tejidos y trabajar con un médico forense o director funerario

- Podemos compartir su información médica con las organizaciones de procuración de órganos.
- Podemos compartir información médica con un oficial de investigación forense, médico forense o director funerario cuando un individuo fallece.

Tratar la compensación de trabajadores, el cumplimiento de la ley y otras solicitudes gubernamentales

- Podemos utilizar o compartir su información médica:
    - En reclamos de compensación de trabajadores.
    - A los fines de cumplir con la ley o con un personal de las fuerzas de seguridad.
    - Con agencias de supervisión sanitaria para las actividades autorizadas por ley.
    - En el caso de funciones gubernamentales especiales, como los servicios de protección presidencial, seguridad nacional y servicios militares.

Responder a demandas y acciones legales

- Podemos compartir su información médica en respuesta a una orden administrativa o de un tribunal o en respuesta a una citación.

Nuestras responsabilidades

- Estamos obligados por ley a mantener la privacidad y seguridad de su información médica protegida.
- Le haremos saber de inmediato si ocurre un incumplimiento que pueda haber comprometido la privacidad o seguridad de su información.
- Debemos seguir los deberes y prácticas de privacidad descritas en esta notificación y entregarle una copia de la misma.
- No utilizaremos ni compartiremos su información de otra manera distinta a la aquí descrita, a menos que usted nos diga por escrito que podemos hacerlo. Si nos dice que podemos, puede cambiar de parecer en cualquier momento. Háganos saber por escrito si usted cambia de parecer.

Para mayor información, visite:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html, disponible en español.

Cambios a los términos de esta notificación
Podemos modificar los términos de esta notificación, y los cambios se aplicarán a toda la información que tenemos sobre usted. La nueva notificación estará disponible según se solicite, en nuestro sitio web, y le enviaremos una copia por correo.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $2500 deductible (in-network) and 20% coinsurance (in-network) and $10000 deductible (out-of-network) and 50% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (602) 903-7999.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (602) 903-7999 for more information.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the DEK Industrial Services, LLC (dba 360 Industrial Services) Welfare Benefits Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (602) 903-7999.

Employer's Children's Health Insurance Program (CHIP) Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more informationon eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos. Para obtener más información, visite **www.cuidadodesalud.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al **1-877-KIDS NOW** o visite **espanol.insurekidsnow.gov/** para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de "inscripción especial", y **usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas**. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de **www.askebsa.dol.gov** o llame al servicio telefónico gratuito **1-866-444-EBSA (3272)**.

Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2022. Comuníquese con su estado para obtener más información sobre la elegibilidad -

ALABAMA – Medicaid	ARKANSAS – Medicaid
Sitio web: http://myalhipp.com Teléfono: 1-855-692-5447	Sitio web: http://myarhipp.com/ Teléfono: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
El Programa de Pago de Alaska primas del seguro médico Sitio web: http://myakhipp.com Teléfono: 1-866-251-4861 Por correo electrónico: CustomerService@MyAKHIPP.com Elegibilidad de Medicaid: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Sitio web: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Teléfono: 916-445-8322 Fax: 916-440-5676 Por correo electrónico: hipp@dhcs.ca.gov

MAINE – Medicaid	NUEVA JERSEY – Medicaid y CHIP
Sitio web por inscripción: http://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-442-6003 TTY: Maine relay 711 Página Web por primos de seguro de salud privado: https://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-977-6740 TTY: Maine relay 711	Sitio web de Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Teléfono de Medicaid: 609-631-2392 Sitio web de CHIP: http://www.njfamilycare.org/index.html Teléfono de CHIP: 1-800-701-0710
MASSACHUSETTS – Medicaid y CHIP	**NUEVA YORK – Medicaid**
Sitio web: https://www.mass.gov/masshealth/pa Teléfono: 1-800-862-4840	Sitio web: https://www.health.ny.gov/health_care/medicaid/ Teléfono: 1-800-541-2831
MINNESOTA – Medicaid	**CAROLINA DEL NORTE – Medicaid**
Sitio web: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Teléfono: 1-800-657-3739	Sitio web: https://medicaid.ncdhhs.gov Teléfono: 919-855-4100
MISSOURI – Medicaid	**DAKOTA DEL NORTE – Medicaid**
Sitio web: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Teléfono: 573-751-2005	Sitio web: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Teléfono: 1-844-854-4825
MONTANA – Medicaid	**CAROLINA DEL SUR – Medicaid**
Sitio web: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Teléfono: 1-800-694-3084	Sitio web: https://www.scdhhs.gov Teléfono: 1-888-549-0820
NEBRASKA – Medicaid	**DAKOTA DEL SUR – Medicaid**
Sitio web: http://www.ACCESSNebraska.ne.gov Teléfono: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Sitio web: https://dss.sd.gov Teléfono: 1-888-828-0059
NEVADA – Medicaid	**OKLAHOMA – Medicaid y CHIP**
Sitio web de Medicaid: http://dhcfp.nv.gov Teléfono de Medicaid: 1-800-992-0900	Sitio web: http://www.insureoklahoma.org Teléfono: 1-888-365-3742
NUEVO HAMPSHIRE – Medicaid	**OREGON – Medicaid**
Sitio web: https://www.dhhs.nh.gov/oii/hipp.htm Teléfono: 603-271-5218 Teléfono gratuito para el programa de HIPP: 1-800-852-3345, ext. 5218	Sitio web: https://healthcare.oregon.gov/Pages/index.aspx http://oregonhealthcare.gov/index-es.html Teléfono: 1-800-699-9075

PENSILVANIA – Medicaid	VIRGINIA – Medicaid y CHIP
Sitio web: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Teléfono: 1-800-692-7462	Sitio web: https://www.coverva.org/es/famis-select https://www.coverva.org/es/hipp Teléfono de Medicaid: 1-800-432-5924 Teléfono de CHIP: 1-800-432-5924
RHODE ISLAND – Medicaid y CHIP	**WASHINGTON – Medicaid**
Sitio web: http://www.eohhs.ri.gov Teléfono: 1-855-697-4347 o 401-462-0311 (Direct RIte Share Line)	Sitio web: http://www.hca.wa.gov Teléfono: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Sitio web: http://pontehipptexas.com/ Teléfono: 1-800-440-0493	Sitio web: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Teléfono de Medicaid: 304-558-1700 Teléfono gratuito: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid y CHIP	**WISCONSIN – Medicaid y CHIP**
Sitio web de Medicaid: https://medicaid.utah.gov/spanish-language Sitio web de CHIP: https://chip.health.utah.gov/espanol/ Teléfono: 1-877-543-7669	Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Teléfono: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Sitio web: http://www.greenmountaincare.org/ Teléfono: 1-800-250-8427	Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Teléfono: 1-800-251-1269

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2022, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.
Administración de Seguridad de Beneficios de los Empleados
www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol
1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.
Centros para Servicios de Medicare y Medicaid
www.cms.hhs.gov
1-877-267-2323, opción de menú 4, Ext. 61565

Declaración de la Ley de Reducción de Trámites

Según la Ley de Reducción de Trámites de 1995 (Ley Pública 104-13) (PRA, por sus siglas en inglés), no es obligatorio que ninguna persona responda a una recopilación de información, a menos que dicha recopilación tenga un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El Departamento advierte que una agencia federal no puede llevar a cabo ni patrocinar una recopilación de información, a menos que la OMB la apruebe en virtud de la ley PRA y esta tenga un número de control actualmente válido de la oficina mencionada. El público no tiene la obligación de responder a una recopilación de información, a menos que esta tenga un número de control actualmente válido de la OMB. Consulte la Sección 3507 del Título 44 del Código de Estados Unidos (USC). Además, sin perjuicio de ninguna otra disposición legal, ninguna persona quedará sujeta a sanciones por no cumplir con una recopilación de información, si dicha recopilación no tiene un número de control actualmente válido de la OMB. Consulte la Sección 3512 del Título 44 del Código de Estados Unidos (USC).

Se estima que el tiempo necesario para realizar esta recopilación de información es, en promedio, de aproximadamente siete minutos por persona. Se anima a los interesados a que envíen sus comentarios con respecto al tiempo estimado o a cualquier otro aspecto de esta recopilación de información, como sugerencias para reducir este tiempo, a la dependencia correspondiente del Ministerio de Trabajo de EE. UU., a la siguiente dirección: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210. También pueden enviar un correo electrónico a ebsa.opr@dol.gov y hacer referencia al número de control de la OMB 1210-0137.

Número de Control de OMB 1210-0137 (vence al 31 de enero de 2023)

Newborns' and Mothers' Health Protection Act Notice

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).

Medicare Part D Creditable Coverage Notice

Important Notice from DEK Industrial Services, LLC (dba 360 Industrial Services) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with DEK Industrial Services, LLC (dba 360 Industrial Services) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. DEK Industrial Services, LLC (dba 360 Industrial Services) has determined that the prescription drug coverage offered by the DEK Industrial Services, LLC (dba 360 Industrial Services) Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current DEK Industrial Services, LLC (dba 360 Industrial Services) coverage will not be affected. Example: Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current DEK Industrial Services, LLC (dba 360 Industrial Services) coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with DEK Industrial Services, LLC (dba 360 Industrial Services) and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Benefits Department at (602) 903-7999. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DEK Industrial Services, LLC (dba 360 Industrial Services) changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	04/07/2022
Name of Entity/Sender:	DEK Industrial Services, LLC (dba 360 Industrial Services)
Contact--Position/Office:	Benefits Department, HR
Address:	2005 W. 14th St. Suite 134 Tempe, Arizona 85281
Phone Number:	(602) 903-7999

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this 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 assistive reproductive services.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name DEK Industrial Services, LLC (dba 360 Industrial Services)	4. Employer Identification Number (EIN) 46-2752036	
5. Employer address 2005 W. 14th St. Suite 134	6. Employer phone number (602) 903-7999	
7. City Tempe	8. State Arizona	9. ZIP code 85281
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (602) 903-7999	12. Email address benefits@360industrialservices.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  ☑ Some employees. Eligible employees are:
  All Full-Time employees working 30 hours or more per week and all classified Field Service Employees
- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Spouse, Dependent Child(ren)

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Aviso de Intercambio de Seguros de Salud

Para los empleadores que ofrecen un plan de salud a algunos o a todos los empleados

Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica

PARTE A: Información general

Cuando entren en vigencia las partes clave de la ley de salud en el 2014, habrá una nueva forma de adquirir seguros médicos: a través del mercado de seguros médicos. A fin de ayudarle mientras evalua las opciones para usted y su familia, este aviso brinda información básica sobre el nuevo mercado y la cobertura médica basada en el empleo que brinda su empleador.

¿Qué es el mercado de seguros médicos?

El mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El mercado ofrece opciones de compra en un solo sitio, para buscar y comparar opciones de seguros médicos privados. También es posible que sea elegible para un nuevo tipo de crédito tributario que reduce su prima mensual de inmediato. El periodo de inscripción para la cobertura de seguro médico a través del mercado comienza en octubre del 2013 para la cobertura que comienza el 1.º de enero del 2014.

¿Puedo ahorrar dinero en las primas del seguro médico que ofrece el mercado?

Es posible que tenga la oportunidad de ahorrar dinero y reducir su prima mensual, pero solo si su empleador no ofrece cobertura médica u ofrece una cobertura que no cumple con determinadas normas. Los ahorros en la prima por la cual puede ser elegible dependen de los ingresos de su familia.

¿La cobertura médica del empleador afecta la elegibilidad para los ahorros en la prima a través del mercado?

Sí. Si su empleador brinda cobertura médica que cumple con determinadas normas, no será elegible para un crédito tributario a través del mercado y es possible que desee inscribirse en el plan de salud de su empleador. No obstante, es posible que sea elegible para un crédito tributario que reduce la prima mensual o para una reducción en la cuota de los costos si su empleador no brinda cobertura o no brinda cobertura que cumple con determinadas normas. Si el costo del plan de su empleador que le brindaría cobertura a usted (y no, a los demás miembros de la familia) supera el 9.5 % del ingreso anual de su familia, o si la cobertura médica que brinda su empleador no cumple con la norma de "valor mínimo" establecida por la Ley del Cuidado de Salud a Bajo Precio (Affordable Care

Act o ACA, por sus siglas en inglés), es posible que sea elegible para un crédito tributario.[†]

Nota: Si adquiere un plan de salud a través del mercado en lugar de aceptar la cobertura médica que brinda su empleador, es posible que pierda las contribuciones (si las hay) que el empleador da para la cobertura médica que brinda. Además, las contribuciones del empleador (así como sus las contributions como empleado para la cobertura médica que brinda el empleador) a menudo se excluyen del ingreso sujeto impuesto federal y estatal. Los pagos para la cobertura médica a través del mercado se realizan después de impuestos.

¿Cómo puedo obtener más información?

Para obtener más información sobre la cobertura que brinda el empleador, consulte el resumen de la descripción del Plan o comuníquese con:

Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

El mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para la cobertura a través del mercado y sus costos. Visite **CuidadoDeSalud.gov** para obtener más información, incluida una solicitud en línea de cobertura de seguros médicos e información de contacto para un mercado de seguros médicos en su área.

PARTE B: Información sobre la cobertura médica que brinda su empleador

Esta sección incluye información sobre la cobertura médica que brinda su empleador. Si decide completar una solicitud de cobertura médica en el mercado, deberá brindar esta información. Esta información está enumerada de forma tal que coincida con la solicitud del mercado.

3. Nombre del empleador DEK Industrial Services, LLC (dba 360 Industrial Services)	4. Número de identificación del empleador (EIN, por sus siglas en inglés) 46-2752036	
5. Dirección del empleador 2005 W. 14th St. Suite 134	6. Número de teléfono del empleador (602) 903-7999	
7. Ciudad Tempe	8. Estado Arizona	9. Código postal 85281

[†] Un plan de salud patrocinado por el empleador cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos.

10. ¿Con quién podemos comunicarnos en relación con la cobertura médica del empleado en este empleo? Benefits Department	
11. Número de teléfono (si difiere del que figura arriba) (602) 903-7999	12. Dirección de correo electrónico benefits@360industrialservices.com

A continuación, encontrará información básica sobre la cobertura médica que brinda este empleador:

- Como su empleador, ofrecemos un plan de salud para los siguientes:
  - ☑ Algunos empleados. Los empleados elegibles son los siguientes:
    All Full-Time employees working 30 hours or more per week and all classified Field Service Employees

- En cuanto a los dependientes:
  - ☑ Sí ofrecemos cobertura médica. Los dependientes elegibles son los siguientes: Spouse, Dependent Child(ren)

☑ Si marca esta opción, esta cobertura médica cumple con la norma de valor mínimo. Asimismo, el costo de la cobertura se pretende que sea asequible para usted según los salarios de los empleados.

Nota: Incluso si el objetivo de su empleador es brindarle cobertura asequible, es posible que sea elegible para obtener un descuento en la prima a través del mercado. El mercado utilizará el ingreso de su grupo familiar, junto con otros factores, para determinar si es elegible para recibir un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a la otra (tal vez es un empleado por hora o trabaja con comisiones), si fue contratado recientemente a mitad de año o si tiene otras pérdidas de ingreso, aún así es posible que reúna los requisitos para recibir un descuento en la prima.

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. 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 Plan coverage when it would otherwise end because of a life event. This is also called 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.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

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

- 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 (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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

How is COBRA continuation coverage provided?

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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[3] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[3] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 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.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

DEK Industrial Services, LLC (dba 360 Industrial Services) Welfare Benefits Plan
Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

Modelo de aviso general de los derechos de la cobertura de continuación de COBRA

(para que usen los planes de salud grupales de un solo empleador)

Derechos de la cobertura de continuación conforme a la ley COBRA

Introducción

Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

Al perder la cobertura de salud grupal, puede haber otras opciones disponibles. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

¿Qué es la cobertura de continuación de COBRA?

La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como “evento especifico”. Los eventos específicos se incluyen más abajo en este aviso. Después de un evento especifico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un “beneficiario que cumple con los requisitos”. Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento especifico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de COBRA must payla cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos especificos:

- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como “hijo dependiente”.

¿Cuándo está disponible la cobertura de continuación de COBRA?

El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento especifico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:

- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).

Para todos los otros eventos especificos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a:

Benefits Department
HR
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

¿Cómo se proporciona la cobertura de continuación de COBRA?

Después de que el administrador del Plan recibe el aviso de que se ha producido un evento especifico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.

La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos especificos, o un segundo evento especifico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA

Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una estensión adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA.

Extensión por un segundo evento especifico del período de 18 meses de la cobertura de continuación de COBRA

Si su familia sufre otro evento especifico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento especifico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o exempleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento especifico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento especifico.

¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un “período de inscripción especial”. Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en www.healthcare.gov.

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del período de inscripción inicial, hay un período de inscripción especial de 8 meses[1] para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.
- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

[1] **www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-period**.

Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes "disminuyan" el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite **www.medicare.gov/medicare-and-you**

Si tiene preguntas

Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite www.dol.gov/ebsa. (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite www.HealthCare.gov.

Informe a su plan si cambia de dirección

Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

Información de contacto del Plan

DEK Industrial Services, LLC (dba 360 Industrial Services) Welfare Benefits Plan
Benefits Department
2005 W. 14th St. Suite 134
Tempe, Arizona 85281
(602) 903-7999
benefits@360industrialservices.com

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address:
http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.