Advocate Aurora Health

Telemedicine
Health Reimbursement Arrangement

Summary Plan Description

AdvocateAuroraHealth

Introduction

Advocate Aurora Health, Inc. ("Advocate Aurora Health") and its affiliates realize the need for quality medical coverage for its team members. Therefore, Advocate Aurora Health has established the Advocate Aurora Health Telemedicine Health Reimbursement Arrangement (the "Telemedicine HRA" or "HRA") to provide participants who terminated between Jan. 1, 2020 to Dec. 31, 2020 with certain telemedicine benefits.

The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code ("Code") and an excepted benefit health reimbursement arrangement as defined by the Code and the Employee Retirement Income Security Act of 1974 ("ERISA").

Advocate Aurora Health has prepared this summary plan description ("SPD") to help you and your dependents understand the medical benefits available to you. The SPD is a summary of the benefits available through the HRA, which is a medical benefit program that is a component of the Advocate Aurora Health Welfare Plan (the "Welfare Plan").

While every effort has been made to accurately describe the HRA, this SPD — as a summary — does not cover all the details of the HRA or how the rules will apply to every person, in every situation. The complete rules that govern the HRA are contained in the official plan document. In the event of a discrepancy between the information contained in this SPD and the official plan document, the plan document will always govern.

The information in this SPD may not be relied on as tax advice for any purpose. Advocate Aurora Health does not guarantee any specific tax consequences. Ultimately, it is your responsibility to determine whether the benefits under this HRA are excludable for tax purposes. For information on how applicable tax law may apply to your personal situation, you should consult your own qualified tax adviser.

Telemedicine HRA benefits are only available to team members who terminated between Jan. 1, 2020 to Dec. 31, 2020. This benefit is no longer offered as a benefit to active team members.

Advocate Aurora Health intends to continue the HRA, but reserves the right to amend, modify or terminate the HRA or the Welfare Plan, in whole or in part, including any benefits provided under the HRA or the Welfare Plan, at any time for any reason. In the event of a change, the plan document will always govern. If the HRA is terminated, your coverage will end; however, you will be entitled to benefits for any covered services incurred before the date the HRA was terminated and you will be notified of any changes to the HRA or the Welfare Plan within a reasonable amount of time and in accordance with any notice requirements under applicable law.

This SPD is not a contract of employment and nothing in this SPD or the Welfare Plan gives any team member the right to be retained in the service of Advocate Aurora Health or any of its affiliated companies.

As used in this document, the word year refers to the benefit year, which is a 12-month period beginning January 1 and ending December 31. All annual benefit maximums accumulate during the benefit year.

The benefits described in this document are provided and funded by Advocate Aurora Health.

Advocate Aurora Health Telemedicine HRA

The Telemedicine HRA is a type of employer provided health reimbursement account. A health reimbursement account generally is a benefit arrangement in which an employer establishes a notional account on an eligible employee's behalf on the employer's books and records, which the employee can use to be reimbursed for eligible medical expenses.

Under the Telemedicine HRA, Advocate Aurora Health will establish a notional account on its books and records on behalf of each eligible team member, which can be used by an eligible team member only for Advocate Aurora Health's Quick Care Video Visits and e-visits. Instead of having a maximum dollar amount available under the Telemedicine HRA, each eligible team member will have a maximum number of Quick Care Video Visits and e-visits each year. If you do not use all of the Quick Care Video Visits and e-visits allocated to your Telemedicine HRA by the end of the plan year, you will lose them; unused benefits do not carry over into the next plan year. You do not contribute to the HRA.

For the benefit year 2020, if you meet the benefits eligibility requirements as referred to in this SPD, you will be offered 20 Quick Care Video Visits and 15 e-visits under the HRA, as described in this SPD. The benefit allocated to your Telemedicine HRA is determined in the sole discretion of Advocate Aurora Health and may be adjusted in future years. In no event, however, will the value of the benefit allocated to your Telemedicine HRA exceed $1,800 per year (this limit may be adjusted in future years in accordance with IRS guidance or regulations).

Advocate Aurora Health will administer the HRA and process claims. If you have questions about your benefits, please contact the AAH Benefits Service Center at 800-775-4784, 7 a.m. – 6 p.m. CT, Monday through Friday.

Eligibility

Team member eligibility

The effective date of the HRA is Jan. 1, 2020 and is only available to team members who terminated between Jan. 1, 2020 and Dec. 31, 2020.

To be eligible to participate in the HRA, you must be eligible to enroll in the Advocate Aurora Health Medical Plan (the "Medical Plan") and have waived coverage under the Medical Plan, either by contacting the AAH Benefits Service Center at 800-775-4784 or failing to enroll during an applicable enrollment period.

In order to be eligible to enroll in the Medical Plan, you must be employed by Advocate Aurora Health or one of its affiliated companies that participates in the HRA (Referred to in this SPD as an "Employer") in one of the following classifications:

Status	Hours worked per pay period	Full Time Equivalent (FTE) rate
Full-Time	72+	.90+
Part-Time A	60-71	.75-.89
Part-Time B	40-59	.50-.74

Satisfying these requirements means that you are a "benefits-eligible" team member or in a "benefits-eligible" position or status.

Further, to receive benefits under this HRA, your primary residence zip code must be in Illinois, Wisconsin, or Michigan. Your residence is based on where you live while employed at Advocate Aurora Health.

Team members who are not eligible to participate in the Medical Plan or who are eligible and have enrolled for coverage under the Medical Plan are not eligible to participate in the HRA.

Dependent eligibility

Your spouse and dependent children are not eligible for benefits under the HRA.

Question...

What happens if I am no longer eligible for benefits under the Medical Plan? If you transfer out of a benefits-eligible position, you will no longer be eligible for the HRA. However, you may be able to continue coverage under the HRA through COBRA (see COBRA Coverage).

Enrollment and HRA details

If you meet the eligibility requirements described in the previous section, you will be automatically enrolled in the HRA.

Advocate Aurora Health reserves the right to periodically audit the eligibility process and request documentation from HRA participants to verify eligibility for the HRA or the payment of benefits under the HRA. Team members found to be involved in acts of dishonesty are subject to disciplinary action, up to and including termination of employment. In addition, HRA participants found to have performed an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact are subject to termination of coverage, prospectively and/or retroactively, to the extent permitted by law.

Quick Care Video Visits

The HRA provides coverage for Advocate Aurora Health's Quick Care Video Visits. Quick Care Video Visits can be used if you are seeking care for low acuity symptoms, such as for breathing problems, bronchitis, colds, coronavirus (COVID-19), cough and sore throat, diarrhea, fever, flu, headaches, red eye, respiratory flu symptoms, respiratory infections, sinus infections, sprains and strains, and vomiting.

Quick Care Video Visits are available 24/7 and are conducted by a dedicated group of Advanced Practice Clinicians. You can request a video visit using the LiveWell app or the MyAdvocateAurora website. After you have exhausted the Quick Care Video Visit maximum benefit, you will be billed a $49/visit fee (which may be adjusted in future years) for any subsequent Quick Care Video Visits. The Quick Care Video Visit benefit is "use it or lose it" - if you do not exhaust the maximum Quick Care Video Visit benefit, those benefits do not roll over into the next year.

E-visits

The HRA provides coverage for e-visits. E-visits can be used if you have low acuity, non-urgent symptoms, such as allergies, back pain, coronavirus (COVID-19), cough, diarrhea, eye discharge, eye drainage, headache, nasal congestion, red eye, respiratory flu symptoms, runny nose, sinus drainage, sinus problems, sore throat, stuffy nose, upper respiratory infection, urinary problems, vaginal discharge or irritation.

E-visits are available 24/7 and are conducted by a dedicated group of Advanced Practice Clinicians. You complete and submit an online questionnaire using the LiveWell app or the MyAdvocateAurora website. A clinician reviews the information you provide and sends you a message back through the LiveWell app or MyAdvocateAurora website with their assessment and recommended next steps. Once you have exhausted the e-visit maximum benefit, you will be billed a $35/visit fee (which may be adjusted in future years) for any subsequent e-visits. The e-visit benefit is "use it or lose it" - if you do not exhaust the maximum e-visit benefit, those benefits do not roll over into the next year.

When coverage begins

Your coverage under the HRA begins when you become eligible for coverage under the Medical Plan - on the first day of the month after you are hired or you transfer into a benefits-eligible position (or on your hire date if your hire date is the first of the month) – and waive coverage under the Medical Plan. The HRA is only available to team members who terminated between Jan. 1, 2020 and Dec. 31, 2020.

When coverage ends

Coverage ends on the same date that you are no longer eligible for benefits under the Medical Plan.

If you are an active team member, your coverage under the Medical Plan ends the earliest of:

- The last day of the month in which your employment with your Employer ends, including your retirement;
- The last day of the month in which you are determined to be no longer eligible for Medical Plan coverage;
- The date you enter the armed forces of any country, except for temporary duty as provided under the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- The date Advocate Aurora Health discontinues the HRA; or
- The Plan Administrator can also terminate coverage for you at any time if you allow an unauthorized person to use your information to receive medical coverage under the HRA or if you submit any false or fraudulent information to the HRA.

All unused benefits under the HRA are forfeited upon coverage termination. However, you may be eligible to continue coverage under the HRA in accordance with federal law beyond the date that coverage would otherwise end if coverage is lost for certain reasons (see COBRA Coverage).

The HRA is not considered minimum essential coverage for purposes of the Affordable Care Act of 2010, and the regulations thereunder, so you will continue to be eligible for subsidies on a public health insurance exchange while participating in the HRA.

The HRA does not coordinate benefits with any other group or individual health coverage. Other than the benefits described in this SPD, the HRA does not provide any additional benefits.

Coverage during a Family Medical Leave Act (FMLA) Absence

If your Employer grants you an approved FMLA leave, HRA coverage will continue during your approved leave as long as you otherwise remain eligible for the HRA.

Coverage will end if:

- Advocate Aurora Health determines your approved FMLA leave is ended, or
- You are no longer eligible for HRA coverage.

If Advocate Aurora Health determines your FMLA leave is over and your coverage ends, you will be eligible for COBRA coverage as if you had ended employment on that day.

Additional information about FMLA leaves is available online at aahbenefits.org.

Coverage during a military leave of absence

You can continue your HRA coverage under the Medical Plan if you leave for military service for less than 31 days — as long as you continue to be eligible for HRA coverage.

If your military leave lasts longer than 31 days, you can continue your HRA coverage until the earlier of:

- The end of the 18-month period beginning on the date you leave for military service, or
- The day your reemployment rights under USERRA end.

If your coverage under the Medical Plan is terminated while you are in military service, it will be reinstated when you return, if you return from military service within the time required under USERRA.

Additional information about coverage during a military leave of absence is available online at aahbenefits.org.

Coverage if you become disabled

If you are receiving disability benefits, you may continue your HRA coverage until your "disability termination date" (generally 6 months after you become disabled), as long as you continue to be eligible for HRA coverage.

Coverage if you are receiving workers compensation benefits

If you are receiving workers compensation benefits, you may continue your HRA coverage until your termination date, as long as you continue to be eligible for HRA coverage.

Claim Administrator and Information

Filing a claim

If you are eligible to receive care under the HRA, you generally will not need to submit a claim because the participating providers will work with the Plan Administrator to process claims directly.

However, in the event that you need to submit a claim for benefits, such claim should be filed with the Plan Administrator as soon as possible after the charge is incurred (generally, within 90 days). Late claims that are filed more than 365 days after the date services were rendered will generally not be paid, unless the charges relate to a previous claim already on file or the delay was due to your legal incapacity.

You may designate a representative to act on your behalf in pursuing a claim or appeal, but this designation must be explicitly stated in writing and must authorize disclosure of protected health information with respect to the claim. If you would like to designate a representative, you will need to contact the Plan Administrator.

Note: As described below, you must follow the procedures under this section to "exhaust" your administrative remedies under the HRA before you can pursue an external review and/or other legal action relating to a claim for coverage or benefits under the HRA.

Payment of claims

Generally, direct payments will be made to the hospital, clinic or physician's office that provided your care or services.

The Plan Administrator reserves the right to request any information required to determine benefits or to process a claim. You or the provider of the services will be contacted if additional information is needed to process your claim.

Eligibility determinations

Determinations of eligibility to participate in the HRA (that do not involve a claim for benefits under the HRA) will be made by Advocate Aurora Health. All decisions made by the company are final and binding. If you have questions about your eligibility, you should contact the AAH Benefits Service Center. If you would like to request a formal determination of your eligibility to participate in the HRA or believe that a determination of your eligibility to participate in the HRA was incorrect, please contact the AAH Benefits Service Center at 800-775-4784, 7 a.m. – 6 p.m. CT, Monday through Friday.

Claims decisions

After submission of a claim, if the claim is denied the Plan Administrator will notify you or your authorized representative (each a "claimant") of the decision in writing or by acceptable electronic means, in a culturally and linguistically appropriate manner, usually within 30 days after receipt of the claim.

However, this period may be extended by an additional 15 days if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the administrator. The Plan Administrator will notify the claimant of the extension before the end of the initial 30-day period, the reason(s) the extension is necessary, and the date by which the Plan Administrator expects to make a decision.

If the reason for the extension is because of the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have at least 45 days from the date of the notice to provide the specified information.

Initial denial notices

A claim denial notice from the Plan Administrator will include:

- Information sufficient to identify the claim involved including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability of the diagnosis and treatment codes and their corresponding meanings (if you request the diagnosis and treatment codes, this information will be provided to you as soon as practicable following your request);
- The specific reason or reasons for the denial;
- The code assigned to the reason for the denial (along with the meaning of the code);
- A description of the standard under the HRA or the Welfare Plan, if any, that was used in denying the claim;
- The specific HRA or Welfare Plan provisions on which the determination is based;
- A description of the internal appeals procedures and external review processes for the HRA (including information about how to appeal a denial and the time limits applicable to such procedures, as well as a statement describing the right to bring a civil action under ERISA Section 502(a) following a final appeal determination);
- 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;
- Contact information for any office of health insurance consumer assistance or ombudsman available to assist the claimant with the internal claims and appeals and external review processes; and
- A description of any internal rule, protocol or similar criterion, if any, that the Plan Administrator relied on to deny the claim (or a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request).

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit under the HRA, the notice will provide either an explanation of the scientific or clinical judgment for the determination (applying the terms of the HRA to the participant's medical circumstances) or a statement that such explanation will be provided free of charge upon request.

Appeals of adverse determinations

A claimant must appeal a claim denial within 180 days after receiving written

notice of the denial (or partial denial). A claimant must make an appeal of the initial claim denial by means of written application, in person, or by mail (postage prepaid), addressed to:

Advocate Aurora Health, Inc.
Non-Church Benefit Plan
Administrative Committee
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515
630-572-9393

A claimant may submit written comments, documents, records, and other information and, upon request and free of charge, will be given reasonable access to (and copies of) all documents, records and other information relevant to the claim. Appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination on appeal will also take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether such information or documentation was submitted or considered in the initial benefit determination. Coverage will continue under the HRA pending the outcome of the appeal, to the extent required by applicable law.

If the denial was based (in whole or in part) on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the medical field involved in the medical judgment. The consulting health care professional will not be the same person who was consulted in connection with the initial denial or a subordinate of that person. The Plan Administrator will identify any medical or vocational experts whose advice was obtained in connection with the denial being appealed, regardless of whether the advice was relied upon in denying the claim.

If any new or additional evidence is considered, relied upon or generated by the HRA as part of the appeal review or if the determination is based on any new or additional rationale, this evidence and rationale will be provided (free of charge) to the claimant as soon as possible and sufficiently in advance of the date on which any notice of a denial of an appeal is required to give the claimant a reasonable opportunity to respond prior to that date.

Time periods for decisions on appeal

Appeals of claim denials will be decided and notice of the decision will be provided as follows:

Appeal denial notices

A notice of a denial on appeal will include:

- Information sufficient to identify the claim involved including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability of the diagnosis and treatment codes and their corresponding meanings. If you request the diagnosis and treatment

codes, this information will be provided to you as soon as practicable following your request;

- The specific reason or reasons for the denial of an appealed claim;
- The code assigned to the reason for the denial (along with the meaning of the code);
- A description of the standard under the HRA or the Welfare Plan, if any, that was used in denying the claim (including a discussion of the decision);
- The specific HRA or Welfare Plan provisions on which the determination is based;
- A description of the internal appeals procedures and external review processes for the HRA (including how to initiate an appeal), and the time limits applicable to such procedures;
- A statement that, upon request and free of charge, the claimant is entitled to reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Contact information for any office of health insurance consumer assistance or ombudsman available to assist the claimant with the internal claims and appeals and external review processes;
- A description of any internal plan rule, protocol or similar criterion that was relied on to deny the appeal (or a statement that a copy of such rule, protocol or similar criterion will be provided to the claimant free of charge upon request);
- An explanation of your right to bring a civil action against the HRA under experimental, investigational or not ERISA Section 502(a) following exhaustion of the internal claims and appeals process for the HRA; and
- 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."
- If the appeal denial is based on medical necessity, experimental, or a similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination (applying the terms of the HRA to the participant's medical circumstances) or a statement that such explanation will be provided free of charge upon request.

Assistance

If you need assistance with the internal claims and appeals processes that are described in this section, you may contact the Illinois ombudsman program at 877-527-9431 or the Wisconsin ombudsman program at 800-236-8517. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 866-444-3272.

Exhaustion

Upon completion of the claims and appeals process under this section, the claimant will have exhausted his or her administrative remedies under the HRA. If the Plan Administrator fails to complete a claim determination or an appeal according to the requirements set forth above (other than a failure that is de minimis, non-prejudicial, due to good cause or matters beyond the Plan Administrator's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance), the claimant may be treated as if he or she has exhausted the internal claims and appeals process and he or she may pursue any available remedies under applicable law. No action at law or in equity may be brought with respect to HRA benefits until all rights under the HRA have been exhausted and any such action must be brought no later than two years from the date of the Plan Administrator's final decision upon review of a second level appeal or the expiration of the applicable limitations period under applicable law (whichever is earlier).

In addition, any suit or claim must be filed in the Northern District of Illinois, Eastern Division. Further, to the extent not preempted by federal law, the HRA and the Welfare Plan shall be interpreted and governed in accordance with the laws of the State of Illinois, as amended from time to time.

When medical coverage ends

COBRA coverage

Team members may continue HRA coverage through COBRA when they would otherwise lose coverage, as described below.

Qualifying events for team members

Coverage can continue for you for up to 18 months if you experience a qualifying event. Qualifying events can occur when you lose your coverage because:

- Your work hours are reduced (including because of a layoff or leave of absence), so that you are no longer in a benefits-eligible position; or
- Your employment ends (except for gross misconduct).

Question...

How much does COBRA cost? COBRA coverage for the Telemedicine HRA will be provided to you at no additional cost.

COBRA coverage and disability

If you are disabled, as determined by the Social Security Administration, on the date you lose coverage or you become disabled during the first 60 days of continuing coverage, you can continue coverage for a total of 29 months (that is, for 11 additional months). You must notify the COBRA administrator within 60 days of the determination of disability, and this notice must be received within the first 18 months of coverage.

Your benefits

Your COBRA coverage under the Telemedicine HRA will consist of the same benefits as active team members and will be automatically provided after you experience a qualifying event for up to 18 months from the date your Telemedicine HRA coverage otherwise would end. Your COBRA coverage under the Telemedicine HRA is subject to the same limitations and exclusions as active team member coverage, including expenses not covered and coordination of benefits.

Applying for COBRA

If you become eligible for COBRA, information about this coverage will be provided to you. You will not need to make an election to be enrolled in COBRA coverage for the Telemedicine HRA.

When COBRA ends

COBRA coverage ends on the earliest of the following dates:

- You become covered under another group health plan that does not contain an exclusion or limit for pre-existing conditions,
- You become entitled to Medicare (except for end-stage renal disease),
- Advocate Aurora Health ceases offering any group health plan coverage, or
- The COBRA period — 18 (or 29) months — ends.

COBRA Administrator

If you have any questions about your eligibility for COBRA, or you do not receive COBRA information within 44 days of your COBRA qualifying event, contact the AAH Benefits Service Center at 800-775-4784.

Administrative Information

Plan name
Advocate Aurora Health Welfare Plan

Plan sponsor
Advocate Aurora Health
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515
630-572-9393

Plan sponsor EIN
82-4184596
Plan Number 501

Plan administrator
Advocate Aurora Health, Inc.
Non-Church Benefit Plan Administrative Committee
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515
630-572-9393

Agent for service of legal process
Chief Human Resources Officer
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515
630-572-9393

Plan year
January 1 to December 31

Type of plan
The Welfare Plan is a welfare benefit plan maintained by Advocate Aurora Health to provide health and welfare benefits for eligible team members. This SPD describes telemedicine benefits provided through an excepted benefit HRA that is part of the Welfare Plan.

Source of benefit payments
The Welfare Plan, including the Telemedicine HRA, is a self-insured, unfunded plan. Benefits are paid from Advocate Aurora's general assets.

Claims administrator/Telemedicine HRA administrators
The Plan Sponsor administers the Telemedicine HRA and is responsible for processing claims and rendering the final decision in all appeals for the Telemedicine HRA.

COBRA administrator
AAH Telemedicine Team
12695 W. National Ave.
New Berlin, WI 53151
844-284-0381

Prudent actions by plan fiduciaries
The Plan Administrator is a fiduciary of the Welfare Plan, including the Telemedicine HRA, and has a duty to fulfill its fiduciary responsibilities prudently and in the best interest of you and other participants and beneficiaries of the Telemedicine HRA.

Advocate Aurora Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Advocate Aurora does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Qualified Medical Child Support Orders (QMCSOs)
A QMCSO is a court order that gives your child the right to be covered under an Advocate Aurora Health – sponsored medical plan. A typical reason courts issue a QMCSO is to protect benefit coverage for children in cases of divorce. The Plan Administrator, in its sole discretion, will determine whether a court order is qualified. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator.

Advocate Aurora Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Vice President of Diversity and Inclusion.

If you believe that Advocate Aurora has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vice President, Corporate Human Resources
750 West Virginia Street
PO Box 341880
Milwaukee, WI 53234-1880
1-800-3-ADVOCATE3

You can file a grievance in person or by mail or email. If you need help filing a grievance, the Vice President, Corporate Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:

www.hhs.gov/ocr/office/file/index.html.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and availability of HIPAA Notice of Privacy Practices

This Federal law imposes requirements on employer health plans, such as the HRA, to take steps to ensure that certain "protected health information" ("PHI") is kept confidential. The Welfare Plan maintains a Notice of Privacy Practices that provides information to individuals whose PHI will be used or maintained by the HRA. If you would like a copy of the Welfare Plan's Notice of Privacy Practices, please contact AAH Benefits Service Center at 800-775-4784.

Statement of ERISA Rights

As a Welfare Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all 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, all documents governing the Welfare Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Welfare 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 Welfare Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Welfare Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue HRA coverage

You may continue coverage for yourself if there is a loss of coverage under the HRA as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the HRA on the rules governing your COBRA continuation coverage rights.

Prudent actions by Plan fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Welfare Plan. The people who operate the Welfare Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Welfare 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 Welfare 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 you the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only if you file suit within 12 months after filing your final request for appeal under the Welfare Plan's claims procedures. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Welfare Plan fiduciaries misuse the Welfare 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 the Welfare Plan, including the Telemedicine HRA, 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.