Administrative and Legal Information

This Summary Plan Description (SPD) contains information about how the plans under the Wayne Services Legacy, Inc. Benefit Program are administered and your rights as a participant as defined under the Employee Retirement Income Security Act of 1974 (ERISA), in effect as of July 1, 2019. Under the provisions of ERISA, the U.S. Department of Labor requires that Wayne Legacy Services, Inc. provide you with this information.

This Summary Plan Description (SPD) is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). If there are any discrepancies between the information contained in this SPD and the official written plan documents, the plan documents will govern.

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Plan Sponsor

The sponsor of all of the Plans is:

Wayne Services Legacy, Inc.

Attention: Benefits Department

5 Wood Hollow Road

Parsipanny, NJ 07054

1-973-617-3500

Plan Administrator

The Plan Administrator for the Medical (including prescription drugs) and Dental insurance plans is:

Wayne Services Legacy, Inc.

Attention: Benefits Department

5 Wood Hollow Road

Parsipanny, NJ 07054

1-973-617-3500

Employer Identification Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service (IRS) to Wayne Services Legacy, Inc. is 83-2589704.

Claiming Benefits

A claim for benefits should be submitted to and will be approved or denied by the appropriate fiduciary, Claims Administrator, insurance company, or Plan Administrator, as designated in each plan. Generally, in-network providers submit claims on your behalf. Appropriate forms and information on how to complete them are available from:

- The Claims Administrator or Insurer's website.

Claims Administration

Official Plan Name	Claims Administrator/Insurance Company	Plan Number	Plan Funding
Wayne Services Legacy, Inc. Health Benefits Plan	*For Aetna Silver Medical Plan* Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 **1-800-589-4811** **www.aetna.com**	501	Wayne Services Legacy, Inc. Self-funded
	For Prescription Drugs: CVS/Caremark PO Box 52136 Phoenix, AZ 85072-2136 **1-877-209-3213** **www.caremark.com**	501	Self-funded
	For Aetna Dental Preferred Provider Organization (PPO): Aetna Inc. P.O. Box 14094 Lexington, KY 40512-4094 **1-800-589-4811** **1-859-455-8650** (Fax for claim submission – Attn: Aetna Dental) **www.aetna.com**	501	Wayne Services Legacy, Inc. Self-funded

Benefits under the Wayne Services Legacy, Inc. Health Benefits Plan are funded through policies of insurance and from the general assets of the company.

The claims review fiduciary has the discretionary authority to interpret the terms of the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final, and binding on all parties. The fiduciary for each Plan is shown in the following table.

Appeal Administration

For These Covered Expenses	Claim Denials are Received from and Appeals Should be Directed to the Appropriate Fiduciary
Medical • Aetna Silver Medical Plan	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 **1-800-589-4811** **www.aetna.com**
• Prescription Drugs – CVS/Caremark	CVS Caremark Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 **1-866-443-1172** (fax number for appeal submission) **1-855-465-0027** (physician-only toll-free number for urgent appeal requests). **www.caremark.com**
Dental • Aetna Dental Preferred Provider Organization (PPO)	**Aetna Dental** Attn: Appeals/Complaints P.O. Box 14080 Lexington, KY 40512 **1-800-589-4811** **1-860-262-7603** (Fax for Appeals Attn: Appeal Coordinator) **www.aetna.com**

Claim and Appeal Procedures For Aetna Silver Medical and Aetna Dental PPO Claims

Filing Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to “you” in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Aetna Appeal Procedures

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply, or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date. You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number **866-444-EBSA (3272)).** If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan. The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Submission of Eligibility & Enrollment Appeals

These procedures apply to claims for eligibility or enrollment in a benefit program.

Filing a First Level Appeal

If you believe that you or your dependent is eligible or entitled to enroll under the Plan or a specific benefit program, you may file an appeal in writing to your Human Resources Representative.

Initial Appeal Decision

When an appeal is received, your Human Resources Representative must notify you of its benefit determination within 30 days of the receipt of the claim. An extension of 30 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

Your Human Resources Representative will provide you the appeal decision verbally. No written communication will be sent. The verbal decision will include:

- Reference the appeal that was reviewed, including applicable plan year, benefits and dependents
- Advise of the approval / denial of the appeal
- The reasons for the approval / denial – based on plan administration design
- Reference specific plan provisions on which the decision was based on, if applicable
- Reference where the team member can obtain additional information on the appeals procedure, if applicable (this can be found in the Administrative and Legal Summary Plan Description)
- If the appeal was approved, advise what changes occurred to the team member's benefits and provide any additional information such as payroll deduction changes and retro-active premiums that the team member may be responsible for or is owed

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect you have the right to further appeal the decision by submitting a written second level appeal form and any additional information for reconsideration, within 60 days after receiving the notice of denial.

A full review will be conducted and responded to within 60 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records, and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge). The relevant documents that must be made available to you include documents, records, and other information that:

- Were relied on in deciding your claim;
- Were submitted, considered or generated in the course of deciding your claim; or
- Demonstrate that the decision complied with the Plan's administrative procedures or safeguards.

You will be furnished a written decision providing the final determination of the claim. The review will take into account all comments, documents, records, and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, you will be notified in writing of the extension within 60 days

of receiving your appeal. The decision will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant documents free of charge; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.

Your written second level appeal form plus any additional information for consideration should be mailed to:

Wayne Services Legacy, Inc.

Att: Benefit Appeals

5 Wood Hollow Road

Parsipanny, NJ 07054

Other Self-Insured Claim Procedures

Generally, the steps below describe your appeal procedures, regardless of the type of claim. A claim is not deemed "filed" for purposes of these claims review procedures until it is filed in accordance with the applicable claims filing procedures established by the applicable Claims Administrator (see General Information section) and it is received by the Claims Administrator.

The following provides additional detail about how your claims appeals are processed for all benefits that are not insured:

- Each level of appeal will be independent from the previous level (in other words, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal)
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim
- You cannot file suit in federal court until you have exhausted these appeals procedures

Step 1: Notice of denial is received from Claims Administrator. If your claim is denied, you will receive written notice from the Claims Administrator that your claim is denied. You will receive notice of the decision within 30 days of receipt of your claim. In addition, the Claims Administrator may request an extension of time in which to review your claim for reasons beyond the Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given 45 days in which to obtain the requested information. The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review your notice of denial carefully. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your final appeal.

Step 3: If you disagree with the decision, file a first level appeal with the Claims Administrator. If you do not agree with the decision of the Claims Administrator and you wish to appeal, you must file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator's letter referenced in Step 1. You should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 4: You receive a notice of the first level appeal from the Claims Administrator. If the claim is again denied, you will be notified by the Claims Administrator within 60 days.

Step 5: Review your first level appeal notice carefully. You should take the same action you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator (see Step 2).

Step 6: If you still disagree with the Claims Administrator's decision, file a second level appeal with the Claims Administrator, if permitted. If you still do not agree with the Claims Administrator's

decision and you wish to appeal, you must file a written second (and final) level appeal to the Claims Administrator within 60 days after receiving the first level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 7: Review your second level appeal notice carefully. If the Claims Administrator denies your second level appeal, you will receive notice within 30 days of receipt of the appeal. The notice will contain the same type of information that was referenced in Step 2 above, including your right to bring a civil action following a denial of your final appeal.

Litigation under Section 502(a) of ERISA

Start of Litigation

No lawsuit may be started under Section 502(a) of ERISA until the appeal procedure previously described is complete or the maximum period to complete the appeal procedure has expired.

Maximum Period to File a Lawsuit

Unless specifically prohibited by applicable state or federal law, no lawsuit may be started under Section 502(a) of ERISA more than two years after an adverse appeal determination was received by you or after the end of the maximum period described in the section titled **Time Periods to Determine Other Appeals of Adverse Benefit Determinations** if a determination is not made by that time.

Summary of Time Limits for Claim and Appeal Determinations

A. Claims for Health Care and Related Benefits

Type of Claim or Appeal	Urgent	Concurrent	Pre-service	Post-service[1]
Initial Claim Determination				
As soon as possible but not later than:	72 hours	Before benefit is reduced or treatment ends; 24 hours if for an extension of urgent care if request is made 24 hours or more before treatment expires; normal decision periods apply for extensions of pre-service and post-service extensions and for urgent care extension requests made within 24 hours or treatment ending or after	15 days	30 days
Extension permitted during initial benefit determination:[2]	None	None	15 days	15 days
Request for appeal of adverse benefit determination must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Appeal of Adverse Benefit Determination				
As soon as possible but not later than:	72 hours	Before benefit is reduced or treatment ends	30 days if level-one appeal; 15 days for each level if a level-two appeal	60 days if level-one appeal; 30 days for each level if a level-two appeal
Extension permitted during appeal of adverse benefit determination:	No	No	No	No

[1] Including claims under Aetna Medical, Dental PPO and the Prescription Drug Plans, unless preauthorization is required, in which case the Pre-service information applies.

[2] Extensions are permitted only if more time is needed due to circumstances beyond the control of the insurer or administrator. No extensions are permitted for urgent or concurrent claims, but if insufficient information is submitted to permit a determination to be made within the time described above, you are allowed up to 48 hours to provide that information, and the determination maximum initial claim determination period is suspended until that information is received by the insurer or administrator.

Legal Service

Legal process for all of the plans may be served on the Plan Administrator:

Wayne Services Legacy, Inc.

Attention: Benefits Department

5 Wood Hollow Road

Parsipanny, NJ 07054

Plan Type and Year

The following table shows the plan type for each of the benefits in the Wayne Services Legacy, Inc. Benefit Program, as well as the:

Plan year – the period during which elections for benefits are effective *and*

Plan year – the legal and reporting period for the plan.

Benefit Plan	Plan Type	Plan Year
Medical	Welfare providing health care benefits	July 1 to June 30
Prescription Drug	Welfare providing prescription drug benefits	July 1 to June 30
Dental	Welfare providing dental benefits	July 1 to June 30

Plan Documents

This Summary Plan Description describes only the highlights of the plans that make up the Wayne Services Legacy, Inc. Benefit Program and does not attempt to cover all details. These are contained in the Plan documents and/or insurance company contracts, which legally govern the Plans and which are controlling in the event of a conflict with this Summary Plan Description. These documents, as well as the annual report of each Plan's operation (which is filed with the U.S. Department of Labor), and each Plan's description are available for review through the Wayne Services Legacy, Inc. Benefits Department during normal working hours. Upon written request to the Plan Administrator, copies of any of these documents will be furnished to a Program member or beneficiary within 30 days at a nominal cost.

Plan Continuation

Wayne Services Legacy, Inc. expects and intends to continue the Medical and Dental benefits but reserves the right to change, modify or terminate the Plans, through its Board of Trustees, in whole or in part, at any time and for any reason. If Medical or Dental benefits are terminated, you will not have the right to any benefits or have any further rights – other than the payment of covered expenses you had incurred before the coverage terminated. Note that all benefits other than Medical, Prescription Drug, and Dental were terminated on 6/30/2018 due to the Company's bankruptcy filing.

Your Rights under ERISA (Employee Retirement Income Security Act of 1974)

The benefits provided by the Wayne Services Legacy, Inc. Benefit Program are covered by ERISA. The law does not require Wayne Services Legacy, Inc. to provide benefits. However, it does set standards for any benefits Wayne Services Legacy, Inc. offers – and it requires that you be given an opportunity to learn what those benefits are and your rights to them under the law. ERISA provides that all plan participants, with appropriate notice, shall be entitled to:

- Examine, without charge, at Wayne Services Legacy, Inc. worksites or on RUsBenefits.com, all documents governing the plans, including the Trust agreement, insurance contracts, and administrative service contracts, plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plans, including the trust agreement, insurance contracts, and administrative service contracts, 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 each 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

HIPAA also requires that you be provided with a certificate of creditable coverage free of charge if you leave Wayne Services Legacy, Inc. You can request a certificate of creditable coverage:

- When you lose health coverage
- When you become entitled to elect COBRA continuation coverage
- When your COBRA continuation coverage ends
- At any time before losing health care coverage

  or
- Up to 24 months after losing health care coverage.

You can use a certificate of creditable coverage to eliminate or reduce any pre-existing condition limitation period under another group health care plan.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. Although these rights are in no way a guarantee or contract of employment, no one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from a plan or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the appropriate fiduciary review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the appropriate Plan Administrator 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 appropriate fiduciary 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 appropriate 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. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order or the status of a qualified domestic relations order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse a 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 pays 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, if, for example, it finds your claim is frivolous.

If you have any questions about these plans, you should contact the appropriate 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 EBSA, 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 EBSA at **1-866-444-EBSA (3272)**.

Legal Notices

This section contains information about your rights and procedures to protect those rights.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - Joint Notice of Privacy Procedures

THIS JOINT 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.

Protection of your Health Information

A. Your Right to Privacy Protection of Your Individually Identifiable

This Joint Notice is being provided to you on behalf of the Wayne Services Legacy, Inc. Health Benefits Plan sponsored by Wayne Services Legacy, Inc. (hereinafter referred to as the "Employer" or the "Health Plan Sponsor"). The Health Plan acquires individually identifiable health information about you and your covered dependents for various employment-related purposes and for claim purposes related to your coverage under any welfare benefit plans or programs sponsored by the Health Plan Sponsor or required by state law. To the extent that the Employer presently or hereafter provides Medical and Dental benefits under the Health Plan, that information is **"Protected Health Information"** and the Health Plan must maintain the privacy of your Protected Health Information under a federal law known as the Health Insurance Portability and Accountability Act (hereafter **"HIPAA")** and requirements called the **"Privacy Rule,"** which are spelled out in detailed regulations of the U.S. Department of Health and Human Services (hereafter **"HHS")** that may be found in volume 45 of the Code of Federal Regulations (hereafter **"CFR"),** Parts 160 and 164. Any state law that requires additional methods to maintain the privacy of your Protected Health Information also applies. The Health Plan and the Health Plan Sponsor will share Protected Health Information with one another for purposes of treatment, payment and health care operations with respect to services provided to you by the Health Plan.

In addition, under HIPAA and the Privacy Rule, the Health Plan must provide you with this notice of its legal duties and privacy practices with respect to that Protected Health Information. This notice explains how the Health Plan provides that protection. The Health Plan reserves the right to change the privacy notice and make the revised notice effective for all Protected Health Information maintained by the Health Plan or Health Plan Sponsor. If any such change is made, you will be provided with a written copy of any material change within 60 days after that change becomes effective.

The Health Plan is required by law to notify you or your covered dependents following a breach of unsecured Protected Health Information.

Insurers and HMOs must also comply with the Privacy Rule, and are required to furnish you with a similar notice as to how they provide protection to Protected Health Information. This Notice only describes how the Health Plan and Health Plan Sponsor will provide such protection to Protected Health Information they receive with respect to the Health Plan. Please note that we provide many of the activities and/or services discussed in this notice through a third party administrator which itself is contractually bound to comply with this Notice.

Individually identifiable health information received by the Employer for plans or programs other than the Health Plan is not Protected Health Information, and HIPAA and the Privacy Rule **do not apply** to such information.

B. Information Acquired Directly By the Plan Sponsor from Sources Other than the Health Plan Is Not Protected Health Information

This information can and will be used and disclosed without your authorization or consent for any claim for benefits under any other pension or welfare benefit plan or program established and maintained by the Plan Sponsor, including but not limited to:

- Requests for certification of coverage of the employee or dependent or for any other lawful employment-related purposes, including but not limited to:
    - Pre-employment drug testing
    - Request for reasonable accommodations under the ADA
    - Request for family or medical leave
    - Submission of a Workers' Compensation claim
    - Physical or mental inability to work while on company premises
    - Post-employment examination following potential exposure to harmful substances or on-the-job injury
    - Any first aid or emergency services in cases of serious illness or injury occurring on Wayne Services Legacy Inc.'s that are provided by a Wayne Services Legacy, Inc. team member while awaiting arrival of an ambulance or emergency medical assistance.

C. Authorizations Are Required for Certain Disclosures of Protected Health Information

The Health Plan, Health Plan Sponsor and/or its insurers, HMOs or third party Claims Administrators may acquire Protected Health Information about you for purposes of your or your enrolled dependents' treatment, payment of benefits or provision of health care services, or for the overall health care operations of the Plan. This Protected Health Information will not be disclosed to anyone without your express written authorization, except as indicated in the provision titled Permitted Uses and Disclosures of Your Protected Health Information without Your Authorization or Consent.

D. Designation of an Authorized Personal Representative

1. Appointment of a Personal Representative:

Under the Privacy Rule, you and each of your covered Dependents may designate a Personal Representative to act on your or their behalf by obtaining a court order pursuant to applicable state or other law (such as tribal or military law) or by signing a valid power of attorney that includes the right to make decisions related to health care. Generally, any court order designating someone as a guardian or executor or administrator or a duly executed power of attorney or health care proxy can serve as such a designation. You can also retain an attorney to deal with your Protected Health Information or other individually identifiable health information. The Health Plan or its delegate has full discretion and authority to determine if any such other authorization or court order is valid.

2. Personal Representatives of Minor Dependent Children:

In most instances, parents are Personal Representatives of their minor dependent children. There are various exceptions which include the following:

- If there is a court order authorizing someone else to make treatment decisions for a minor child, a parent cannot be the child's authorized Personal Representative.
- Under the laws of some states, older minor children may obtain their own health care services without the knowledge or consent of their parents. In those states, parents are not authorized Personal Representatives in the absence of specific written authorization from the child.

3. Employees and Spouses:

Most employees and their spouses expect that it is in their best interest for each of them to be able to receive Protected Health Information relating to the other in order to deal with problems related to their health care treatment, access to health care services, or payment of benefits, both in general and with respect to emergencies (such as when one spouse cannot make decisions).

However, some employees and/or their spouses may not want the other spouse to have access to their Protected Health Information or other individually identifiable health information either generally or in specific circumstances.

The Health Plan Sponsor and/or the Health Plan Administrator or its delegates, with respect to all benefit plans or programs, including the Health Plan, will accommodate both situations as follows:

- In the absence of any written statement from an employee or spouse to the contrary, the Health Plan or its delegates on behalf of all its welfare benefit plans or programs, including the Health Plan, will generally assume that it is in the individual's best interest to communicate with the employee and his or her spouse regarding each other's PHI as necessary for appropriate purposes.
- Any written request on the Health Plan's form that is delivered to the Plan Sponsor or the Health Plan Privacy Officer by an employee and/or spouse requesting that the other spouse **should not receive his or her Protected Health Information** will be kept on file and we will make reasonable efforts to honor the requests.

E. Your Right to Complain About Violations of Your Right to Privacy Protection

If you believe your privacy rights have been violated, you may file a complaint with the Plans or with the Secretary of HHS. To file a complaint with the Plans, contact:

Privacy Complaints
Wayne Services Legacy, Inc.
Attention: Benefits Department
5 Wood Hollow Road
Parsipanny, NJ 07054
1-973-617-3500

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Complaints may also be made in writing to the Secretary of the U.S. Department of Health and Human Services. Neither the Health Plan nor the Employer will retaliate against you if you file any such complaint.

F. Effective Date of This Notice and Procedures

This notice and procedures are effective as of September 23, 2013.

Permitted Uses and Disclosures of Protected Health Information without Your Authorization or Consent

A. Disclosure for Treatment, Payment of Benefits and Health Care Operations

The Plan and Health Plan Sponsor can use or disclose your Protected Health Information, without your written consent or authorization, for purposes of your treatment, payment of benefits, or health care operations. For each of these categories of use and disclosure we have provided a description and example below, however, not every particular use or disclosure in every category will be listed.

Covered Entities and Their Business Team members

For purposes of this Notice, **"Covered Entity"** refers to the Health Plan.

- A **"Business Team member"** is an entity, including a third party Claims Administrator of the Health Plan, that:
- Provides related services to the Health Plan or any Covered Entity; and
- Has entered into an agreement with a Covered Entity under which it agrees to abide by the rules and regulations established pursuant to federal law and regulations to protect the privacy of your Protected Health Information.

"Payment of Benefits" includes the processing of requests for benefit payments by the Health Plan for health care services provided to you or any of your covered Dependents.

Uses and Disclosures for Treatment

Treatment means the provision, coordination or management of your health care. Examples of uses and disclosures that will be made for treatment include, but are not limited to the following:

- The Health Plan may disclose the name of your primary care physician to a specialist who is treating you or any of your covered Dependents so that the specialist can get needed information to provide adequate health care services.
- The Health Plan may disclose any Protected Health Information to any other health plan or program, or health care provider to facilitate your or any of your covered Dependents' treatment or access to health care services.

Uses and Disclosures Made for Payment of Benefits

Payment means the activities the Health Plan undertakes to provide reimbursement for health care provided to you including making remittances, claims management, determinations of eligibility and coverage and utilization review activities. Examples of the uses and disclosures that will be made to any Covered Entities and/or their Business Team members for **payment of benefits** include, but are not limited to:

- The Health Plan may request additional information from your health care provider about your medical condition to determine whether the proposed course of treatment will be covered.
- The Health Plan may tell your or any of your covered Dependents' health care providers that you or your covered Dependents are eligible for coverage, and what benefits the Health Plan provides.
- The Health Plan may disclose your Protected Health Information to any other health plan or program, Covered Entity, or Business Team member in order to process, or expedite the processing of, premium payments for your coverage, and/or your or any of your covered Dependents' claims for benefits or requests for health care services.
- The Health Plan may refer your Protected Health Information to any other health plan or program that covers you or any of your covered Dependents to administer the plan's coordination of benefit or third party recovery provisions.

Uses and Disclosures Made for Health Care Operations

Health care operations means the support functions of the Health Plan, related to Payment of Benefits, such as large case management, receiving and responding to your comments and complaints, management and other administrative activities.

The Health Plan may disclose your Protected Health Information to any other Covered Entity or Business Team member in order to provide assistance to the operations of the Health Plan in its administration or operation. Examples of the uses and disclosures that will be made to any Covered Entities and/or their Business Team members for **health care operations** include, but are not limited to:

- Referral to a case management or disease management program to determine if any more effective and/or less costly course of treatment of your or any of your covered Dependents' condition is available.
- Review or audit of the services of any of the Health Plans, or any Covered Entity or Business Team member related to any of the Health Plans, with respect to quality, timeliness, accuracy, and/or compliance with laws and regulations.

Although underwriting falls within the definition of health care operations, the Health Plan will not use or disclose genetic information for purposes of underwriting. Genetic information is defined under the Genetic Information Nondiscrimination Act (GINA).

Examples of Other Disclosures That May Be Made Without your Authorization

- The Health Plan or its third party administrator may disclose Protected Health Information to the Employer, but that information will be used **only for plan administration and related purposes, and not for any other employment-related purpose.**
- Subject to applicable law, we may make incidental uses and disclosures of Protected Health Information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

Disclosures Required by Law

The Health Plan will disclose your Protected Health Information without your written consent or authorization when required by law. Most disclosures required by law usually would be made by health care providers rather than by a Health Plan. Some examples of such disclosures include, but are not limited to:

- **Public health activities** (when applicable law requires disclosure that a Health Plan participant was exposed to a communicable disease).
- **Abuse, neglect or domestic violence** (when the law requires disclosure if the circumstances indicate that such event might have occurred).
- **Law enforcement purposes** (if a Health Plan participant is treated for gunshot or other types of wounds or if the information may help apprehend someone other than the Plan participant who is suspected of a crime).
- **Requests from a coroner or medical examiner** (to identify a deceased. person or determine the cause of death).
- **Requests from a funeral director** (to help carry out his or her duties).
- **Disaster Relief** (when permitted by law, we may coordinate our uses and disclosures of Protected Health Information with public or private entities authorized by law or by charter to assist in disaster relief efforts).
- **Organ and Tissue Donation** (if you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation).
- **Military and Veterans** (if you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority).
- **Protective Services for the President and Others** (we may disclose health information about you to authorized Federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or may conduct special investigations).
- **Inmates** (if you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you

with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution).

- **Serious Threats** (as permitted by applicable law, we may use and disclose Protected Health Information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual).

The following are examples of disclosures **required by law** that are more likely to be made by a Health Plan:

- **Compliance with Workers' Compensation laws** (to administer the Workers' Compensation program).
- **Subpoenas or requests for discovery** (issued by any court or government agency or other judicial or administrative body).
- **Oversight activities authorized by law** (including government investigations of possible crime or fraud).
- **Requests by the Secretary of the U.S. Department of Health and Human Services (HHS)** for purposes of enforcement of the Privacy Rule.

Authorizations to Disclose Protected Health Information

A. Written Authorization to Disclose Protected Health Information

Other uses and disclosures of your PHI not described above will only be made with your written authorization. For example, your authorization is required for most uses and disclosures of psychotherapy notes (if applicable), uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

The authorization must meet the requirements spelled out in section B below. If a covered Dependent is legally incapable of providing an authorization, that covered Dependent's parent, legal guardian or other Personal Representative may provide that authorization.

B. Contents of a Written Authorization to Disclose Protected Health Information

No disclosure of Protected Health Information will be made unless the written authorization is made on an authorization form provided by the Health Plan, or if the Health Plan Administrator or its delegate determines, in the exercise of its sole discretion, that any other document contains all of the following elements:

1. Specific **identification of the person** whose Protected Health Information is to be disclosed.
2. A specific **description of the information** that is to be disclosed.
3. Specific **identity of the Health Plan** that is to disclose the Protected Health Information.
4. Specific **identification of the person or entity** to which the Protected Health Information is to be disclosed.
5. A general explanation of **why the request for disclosure** of Protected Health Information is made.
6. A specific **expiration date or event** for the authorization to disclose Protected Health Information.

7. Your or your covered Dependent's **signature** or the signature of your or your covered Dependent's authorized representative, and the **date** on which the authorization was signed.

C. Information Accompanying the Authorization to Disclose Protected Health Information

Each authorization to disclose Protected Health Information must include the following written statements and information:

1. A statement that the authorization is **revocable** at any time after it is given, and an explanation of how you or your covered Dependent (or any authorized Personal Representative) may revoke it.
2. A statement that once the Protected Health Information is disclosed pursuant to the authorization, it may not be protected against re-disclosure by the recipient.
3. Statements that the Health Plan may not require the authorization as a precondition for participation in the Health Plan, and except in certain circumstances specified by the Privacy Rule.
4. A statement that you and/or your covered Dependent (or any authorized Personal Representative) is entitled to **receive a copy** of the signed authorization. You and/or your covered Dependent (or Personal Representative) may be required to sign an **acknowledgement of receipt** of that copy.

Note: **HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially Protected Health Information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.**

Your Rights Under the Privacy Rule

Pursuant to applicable law and regulations, you and your covered Dependents have the following rights:

A. Right to Request Restrictions on Disclosures for Treatment, Payment of Benefits and/or Health Care Operations

1. You, your covered Dependents, and/or Personal Representatives have the right to request restrictions on the Health Plan's disclosure of your or their Protected Health Information to Covered Entities and/or their Business Team members for treatment, payment and/or health care operations, or to members of your family, other relatives or close personal friends who are directly involved with or responsible for your (or your covered Dependent's) care or payment for that care.
2. **However, the Health Plan is authorized by law and regulations to refuse to honor any request to restrict the Health Plan's disclosure to Covered Entities and/or their Business Team members for treatment, payment, and/or health care operations. Except as provided in the next paragraph, these types of requests will not be honored.**

   Effective February 17, 2010 (or such other date specified as the effective date under applicable law), the Health Plan will comply with any restriction request if:

   (i) Except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment, and

   (ii) The PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

3. You may request restrictions by submitting a written request to the Health Plan.

B. Right to Confidential Communications About Protected Health Information

1. You, your covered Dependents, and/or Personal Representatives have the right to request in writing to receive confidential communications about any of your or their Protected Health Information by alternative means or at alternative locations (for example, when you or one of your covered Dependents does not want anyone else, including other family members, to have access to that Protected Health Information).
2. If you, your covered Dependent and/or Personal Representatives provide a statement that the disclosure of all or part of your or your covered Dependent's Protected Health Information to which you or your covered Dependent's request pertains could endanger you or your covered Dependent if not sent by the alternative means or to the alternative locations, and the request is reasonable, we will comply with the request.
3. In other circumstances, the Health Plan is not required to comply with your request although it may choose to do so depending on the circumstances.
4. You may request confidential communications by submitting a written request to the Health Plan.

C. Right to Inspect and Copy Your Own Protected Health Information

1. You, your covered Dependents, and/or Personal Representatives have the right to inspect and copy your or your covered Dependent's Protected Health Information, as applicable, maintained in the Health Plan's files (or if the request is made to any other Covered Entity, the information maintained in that Covered Entity's files), except for:

   - Psychotherapy notes
   - Information maintained by a Covered Entity pursuant to the Clinical Laboratory Improvements Amendments of 1988, to the extent applicable under that law
   - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding
   - Protected Health Information created or obtained by a health care provider as part of a research study; your access to such health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
   - Protected Health Information contained in records kept by a Federal agency or contractor when your access is restricted by law

     And,

   - Protected Health Information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

2. We may also deny access for the following reasons, provided you or your covered Dependent may have the right to have that denial reviewed under any of the following circumstances:

   - A licensed health care provider has determined that the access requested is likely to endanger your or your covered Dependent's life or physical safety or that of another person.
   - That information refers to another person, and a licensed health care provider has determined that the access requested is likely to endanger that person's life or physical safety.
   - The request is made by your or your covered Dependent's Personal Representative and a licensed health care provider has determined that the access requested is reasonably likely to cause substantial harm to you or another person.

3. The following administrative procedures apply:

    - You may request access by submitting a written request to the Health Plan.
    - The Health Plan will generally act on your request within 30 days after it is received.
    - You or your covered Dependent may be charged the reasonable costs for copying the Protected Health Information, postage or other charges incurred in mailing or sending that information to you or your covered Dependent, and the preparation of any requested explanation or summary of that information.
    - You or your covered Dependent will be advised of your right to appeal a denial of that information if you or your covered Dependent has such a right, or that you or your covered Dependent has no such right if it is not available.
    - If the Health Plan does not maintain that information and knows where that information is maintained, you or your covered Dependent will be advised where to direct your request for access to it.

D. Right to Amend Your Protected Health Information:

1. You, your covered Dependents, and/or Personal Representatives have the right to amend your or your covered Dependent's Protected Health Information if that request is in writing, and includes a reason to support the requested amendment. However, the Health Plan may deny your request if the Protected Health Information:

    - Was not created by the Health Plan, unless you provide us with a reasonable basis to believe that the creator of that information is not available to act on the request to amend that information.
    - Is not part of the medical or billing records of the Health Plan or other records used by the Health Plan to make decisions about you
    - Would not be available for inspection, as indicated in the section titled Right to Inspect and Copy Your Own Protected Health Information.
    - Is accurate and complete.

2. The following administrative procedures apply:

    - You may request amendment by submitting a written request to the Health Plan.
    - The Health Plan will act on the request within 60 days after it is received or within an additional 30 days if it cannot do so within that 60-day period.
    - If the amendment is accepted, the Health Plan will make reasonable efforts to inform you or your covered Dependent when that amendment is made, and will provide a copy of it to anyone else who you or your covered Dependent identify as having received Protected Health Information about you or your covered Dependent and needing the amendment and anyone else the Health Plan knows has the unedited Protected Health Information and may have relied, or could reasonably rely, on it to you or your covered Dependent's detriment, and thus needs to have that amendment.
    - If the request is denied, you, your covered Dependent and/or Personal Representative will be informed of the reason for the denial, and you or your covered Dependent will be advised of your or your covered Dependent's right to file a statement of disagreement and/or to seek further relief from that denial.
    - If the Health Plan does not maintain that information and knows where that information is maintained, you or your covered Dependent will be advised where to direct your request for access to it.

E. Right to Receive an Accounting of Disclosures of Protected Health Information

1. You, your covered Dependents, and/or Personal Representatives have the right to receive an accounting of disclosures of your or your covered Dependent's Protected Health Information, **except for disclosures:**

   - To carry out treatment, payment and/or health care operations, as described above.
   - To you about your Protected Health Information.
   - Incidental to a use or disclosure permitted or otherwise required by applicable law or regulation.
   - To persons involved in your care or for notification purposes as provided by law.
   - Pursuant to your or your covered Dependent's written authorization.
   - For national security or intelligence purposes, as required by applicable law or regulation.
   - To correctional institutions or law enforcement officials, as required by applicable law or regulation.
   - That occurred before April 14, 2003, the date on which compliance by the Health Plan was required by law.

2. The following administrative procedures apply:

   - You may request an accounting by submitting a written request to the Health Plan.
   - The Health Plan will act on the request within 60 days after it is received or within an additional 30 days if it cannot do so within that 60-day period.
   - You or your covered Dependent may be charged the reasonable costs for copying the Protected Health Information, postage or other charges incurred in mailing or sending that information to you or your covered Dependent, but no charge will be made for the first accounting requested within any 12-month period. If you or your covered Dependent refuse to consent to paying any such charges, the request will be considered to have been withdrawn.
   - The accounting will include:
     - The date of each disclosure.
     - The name and, if known, the address of each recipient.
     - A brief description of the information provided.
     - A brief statement of the purpose of the disclosure, or a copy of the written request for that disclosure.
   - If the Health Plan does not maintain that information and knows where that information is maintained, you or your covered Dependent will be advised where to direct your request for access to it.

F. Right to be Notified of a Breach.

You have the right to be notified in the event that the Health Plan (or a business associate of the Health Plan) discovers a breach of unsecured Protected Health Information.

G. Right to Receive a Paper Copy of the Privacy Notice and Other Information

You have the right to obtain a paper copy of the notice at any time upon request. If you, your covered Dependent, and/or Personal Representatives wish to obtain a copy of the notice or have any questions about this notice, the Privacy Rule, or your rights as applied to your individual circumstances, contact the address shown in Your Right to Complain about Violations of Your Right to Privacy Protection. You can also access the privacy notice at **www.rusbenefits.com**.

HIPAA Special Enrollment Rights for Group Health Plans

- If you, your spouse, domestic partner and/or dependent are entitled to special enrollment rights under the medical or dental benefit options, an election change to correspond with the special enrollment right is permitted.
- Thus, for example, if an otherwise eligible employee declined enrollment in medical coverage for the employee or the employee's eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, exhaustion of COBRA period, moving out of or no longer working in an HMO service area, or reaching a lifetime maximum for a benefit), the employee may be able to elect medical coverage under the Plan for the employee and his or her eligible dependents who lost such coverage.
- Furthermore, if an otherwise eligible employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may also be able to enroll the employee, the employee's spouse, and the employee's newly acquired dependent, provided that a request for enrollment is made within **30 days from the date of the event**; however, in cases where the special enrollment right is triggered by a loss of eligibility for Medicaid or the state's Children's Health Insurance Program (CHIP) or becoming eligible for premium assistance subsidy under Medicaid or CHIP, such request must be made within **60 days after such event**. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 31 days.
- You are eligible to enroll in the medical (including the Limited Purpose FSA), dental, and/or vision benefit option outside of the Annual Enrollment period if you or your eligible dependent: (1) is enrolled in Medicaid or CHIP and coverage is terminated due to a loss of eligibility for coverage under Medicaid or CHIP; or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP. However, you must request enrollment within **60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable.

Contact your Human Resources Representative to request a special enrollment.

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, 2019. Contact your State for more information on eligibility –

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	**GEORGIA - Medicaid**
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	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS - Medicaid	INDIANA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid	**KANSAS - Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY - Medicaid	**NEW HAMPSHIRE - Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll Free: 1-800-852-3345 ext 5218
LOUISIANA - Medicaid	**NEW JERSEY - Medicaid and**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE - Medicaid	**NEW YORK - Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI - Medicaid	**OKLAHOMA - Medicaid and**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA - Medicaid	**OREGON - Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-

NEBRASKA - Medicaid	PENNSYLVANIA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m
NEVADA - Medicaid	**RHODE ISLAND - Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA - Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.c fm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.c fm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/premium-payment- program Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	**WEST VIRGINIA - Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid and CHIP	**WISCONSIN - Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.p_df Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, 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)

Or
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.

Complaints

General Contact Information

The Plan Sponsor is the privacy contact for the Plans:

Wayne Services Legacy, Inc.
Attention: Benefits Department
5 Wood Hollow Road
Parsipanny, NJ 07054
1-973-617-3500

For insured benefits options, contact the insurer.

Genetic Information Non-discrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of the Health Insurance Portability and Accountability Act (HIPAA), generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans offering group health coverage generally may not:

- 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
- Set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
- Require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceed 48 hours (or 96 hours). For information on pre-certification, please refer to your medical plan Summary Plan Description (SPD).

Notice Regarding Women's Health and Cancer Rights Act

Under our health plans, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

  and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Coverage may be subject to annual deductibles, copays and coinsurance, consistent with those established for other benefits provided by the plan.

If you have any questions about coverage of mastectomies and reconstructive surgery, please contact your medical plan **Claims Administrator**.

General Notice of COBRA Continuation Coverage Rights

You are receiving this information as a participant in the group medical and dental plans provided by Wayne Services Legacy, Inc. This notice contains important information about your right to continuation of health coverage, which is a temporary extension of coverage under the group medical, dental and/or vision options, employee assistance program, or the health flexible spending arrangement under the Program. 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 to other members of your family who are covered under the Program when you would otherwise lose this health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plans and under federal law, you should contact the COBRA Administrator:

WageWorks
1-800-526-2720

The COBRA Administrator is responsible for administering COBRA continuation coverage.

When Medical and Dental Coverage Ends

Unless the participant elects COBRA coverage, medical and dental coverage ends as of the date on which:

- The Program is terminated
- You no longer meet the eligibility requirements as an active team member of the Wayne Services Legacy, Inc. Benefit Program
- You leave Wayne Services Legacy, Inc.

  or
- You fail to pay any required contributions as described under this notice on continuation coverage (COBRA).

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Program because of a qualifying event. Only qualified beneficiaries may elect to continue their group health plan coverage. Depending on the type of qualifying event, team members, spouses or domestic partners of team members, and their dependent children may be qualified beneficiaries. (Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Continuation coverage is the same coverage that the Program gives to other participants or beneficiaries under the Program who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plans as other participants or beneficiaries covered under the Program, including Annual Enrollment and special enrollment rights.

Specific information describing the coverage to be continued under the Program is contained elsewhere in this notice. For more information about your rights and obligations under the Program, you can get a copy of additional information from the COBRA or Plan Administrator.

If you are a team member, you will become a qualified beneficiary if you will lose your coverage under the Program because one of the following qualifying events happens:

- Your hours of employment are reduced or you transfer to an ineligible class of employment

  or

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or qualified domestic partner of a team member, you will become a qualified beneficiary if you lose your coverage under the Program because any of the following qualifying events happens:

- Your spouse/domestic partner dies
- Your spouse's/domestic partner's hours of employment are reduced or your spouse/domestic partner transfers to an ineligible class of employment
- Your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct
- Your spouse/domestic partner becomes enrolled in Medicare (Part A, Part B, or both)

  or

- You become divorced or legally separated from your spouse or your domestic partnership terminates. If a team member cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the divorce or legal separation and can establish that the team member cancelled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

Your dependent children and/or the qualified dependent children of your spouse or domestic partner will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:

- The parent-team member dies
- The parent-team member's hours of employment are reduced or the parent-team member transfers to an ineligible class of employment
- The parent-team member's employment ends for any reason other than his or her gross misconduct
- The parent-team member becomes enrolled in Medicare (Part A, Part B, or both)
- The parents become divorced or legally separated or their qualified domestic partnership terminates

  or

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

Notifying the COBRA Administrator of Qualifying Events

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment transfer to an ineligible class of employment or death of the team member, the employer must the COBRA Administrator of the qualifying event within 30 days following the date coverage ends.

Important: For the other qualifying events (divorce or legal separation of the team member, termination of the team member's qualified domestic partnership, a dependent child losing eligibility for coverage or enrollment of the team member in Medicare (Part A, Part B, or both)), *you* must notify the **COBRA Administrator**. The Program requires you to notify the **COBRA Administrator** within 60 days after the later of the qualifying event or the loss of coverage, using the procedures specified below. **If these procedures are not followed during the 60-day notice period, any spouse, dependent child or qualified domestic partner who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE. You must notify the COBRA Administrator in accordance with the description below of the required information and/or documentation.**

Notice Procedures

First Notice:

You must call the COBRA Administrator at **1-800-526-2720** no later than the last day of the required notice period. Any notice you provide must state the name of the medical, dental, vision and/or employee assistance program options previously elected under the Program (or in the case of the health flexible spending arrangement, the amount of your annual contribution election), the name and address of the team member covered under the plans, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Subsequent Notice:

Your notice of a second qualifying event also must name the event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination.

Electing COBRA Continuation Coverage

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

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the team member and the team member's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. **A qualified beneficiary must elect coverage by returning the COBRA Election Form to the COBRA Administrator within 60 days of being provided a COBRA election notice, (or the date health care coverage stops, if later) and following the procedures specified on the Election Form.** (A copy of

the Program's Election Form may be obtained from the COBRA Administrator.) Your written notice must be provided to the COBRA Administrator at the address provided on the Program's Election Form. If you mail your election, it must be postmarked no later than the last day of the 60-day election period. **If you or your spouse/domestic partner or dependent children do not elect continuation coverage within the 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.** A qualified beneficiary may change a prior rejection of continuation coverage any time until the end of the 60-day election period, in writing, by using the Election Form and following the procedures specified on the Election Form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your health coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the team member, enrollment of the team member in Medicare (Part A, Part B, or both), your divorce or legal separation, termination of your qualified domestic partnership, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the team member's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

An 11-month extension of coverage may be available if any of the qualified beneficiaries in your family is disabled. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension**, for a total maximum of 29 months,** if one of them qualifies. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of **continuation coverage, and you must notify the COBRA Administrator of that fact in writing, using the procedures specified above, in the section entitled Notice Procedures, within 60 days of the SSA's determination AND before the end of the first 18 months of continuation coverage. If these procedures are not followed or if a written notice of a disability is not provided to the COBRA Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.**

If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days of the SSA's determination, using the procedures specified above, in the section entitled **Notice Procedures**. COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled. **The plans reserve the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.**

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

An 18-month extension of coverage will be available to spouses/domestic partners and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second

qualifying event occurs is **36 months**. Such second qualifying events include the death of a covered team member, divorce or separation from the covered team member, termination of the qualified domestic partnership of the covered team member, the covered team member's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the plan.

Upon the occurrence of a second qualifying event, **you must notify the COBRA Administrator in writing within 60 days after the second qualifying event occurs using the procedures specified above, in the section entitled Notice Procedures. If these procedures are not followed or if a written notice of a second qualifying event is not provided to the COBRA Administrator within the required period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Medicare Extension for Spouse/Domestic Partner and Dependent Children

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered team member becomes entitled to Medicare, then the maximum coverage period for the spouse/domestic partner and dependent children will end three years from the date the team member became entitled to Medicare (but the covered team member's maximum coverage period will be 18 months).

Termination of COBRA Continuation Coverage before the End of the Maximum Coverage Period

Continuation coverage will be terminated before the end of the maximum period if: (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) Wayne Services Legacy, Inc. ceases to provide any group health plan for its team members. Continuation coverage may also be terminated for any reason the plans would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. You must use the notice procedures specified above in the section entitled **Notice Procedures**. The Program reserves the right to retroactively cancel COBRA coverage and in that case will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost of the group health plan (including both employer and team member contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%).

Payment for Continuation Coverage

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage within ***45* days** after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) **If you do not make your first payment for continuation coverage within those *45* days, you will lose all continuation coverage rights under the plans.**

Your first payment must cover the cost of continuation coverage from the time your coverage under the plans would have otherwise terminated **up to the end of the month in which you return your COBRA Election Form. Claims under COBRA coverage will not be processed for this initial period until the COBRA Administrator receives payment.** You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the **COBRA Administrator** *to* confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the plans, these periodic payments for continuation coverage are due **each month on the first day of the month. Once the initial premium has been paid, you will receive instructions on how to make future payments.**

Periodic payments for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates described above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the plans will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claims under COBRA coverage will not be processed for any period until the COBRA Administrator receives full payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the plans and will not be reinstated in the plan.

More Information about Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption with the Covered Team Member during COBRA Period

A child born to, adopted by or placed for adoption with a covered team member during a period of continuation coverage is considered to be a qualified beneficiary provided the covered team member is a qualified beneficiary and has elected continuation coverage for him or herself. The child's COBRA coverage begins when the child is enrolled in the plans, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other dependents of the team member. To be enrolled in the plans, the child must satisfy the otherwise applicable plan eligibility requirements. The team member must notify the COBRA Administrator on the appropriate form and pay the additional contributions, if applicable.

Alternate Recipients under a Qualified Medical Child Support Order (QMCSO)

A child of the covered team member who is receiving benefits under the plans pursuant to a Qualified Medical Child Support Order (QMCSO) received by the COBRA Administrator during the covered team member's period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered team member, regardless of whether that child would otherwise be considered a dependent.

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.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the **COBRA Administrator** or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Program Informed of Address Changes

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

Continuation Coverage during Leaves of Absence Granted to Comply with Federal Law

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

This federal law generally allows individuals called for military service to continue coverage for themselves and their dependents under the Plan. If you are on an approved military leave, you and your family can continue coverage for the duration of your leave – up to a maximum of five years – at the applicable team member contribution rate. If military service is longer than five years, you and your family may continue medical, dental, vision and Employee Assistance Program (EAP) coverage through COBRA. See the **COBRA** section of this SPD for more details.

Family Medical Leave Act of 1993 (FMLA)

This federal law generally allows team members on an approved FMLA leave to continue coverage under the Plan for themselves and their dependents for the duration of the approved leave, provided any required premiums are paid by the team member.

When Coverage is Not Continued

If you don't continue your benefits during the leave or if you fail to make any of the required payments, you lose coverage effective the end of the month for which the last payment was made. You will receive information concerning your rights under COBRA at that time. When you return from leave, the benefits you had before your leave, or the benefits that are available upon your return from leave, will be reinstated as required by law unless you have made changes during Annual Enrollment or as a result of a qualified status change. If you do not return to employment, Wayne Services Legacy, Inc. may collect any unpaid contributions, as permitted by law.

State law may provide additional rights.

For more information about continuation of coverage during an approved leave of absence, see **Eligibility and Enrollment** or contact your Human Resources Representative.