
Farella Braun + Martel LLP

Health and Welfare Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2024

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Farella Braun + Martel LLP or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is **not** a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is not a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Farella Braun + Martel LLP Health and Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a “Benefit Description”). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Farella Braun + Martel LLP Health and Welfare Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	April 1, 1987. The Plan has been amended several times since its original effective date, most recently as of January 1, 2024.
Funding Medium and Type of Plan Administration:	<p>Benefit programs are fully-insured. Benefits are insured under a group contract entered into between the Company and insurance companies or HMO.</p> <p>The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.</p> <p>Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.</p>

The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.

Plan Sponsor:

The employer is the Plan Sponsor.

Farella Braun + Martel LLP
One Bush Street, Suite 900
San Francisco, CA 94104
(415) 954-4748

**Plan Sponsor's Employer
Identification Number:**

94-1527242

Insurance Companies/HMO:

See a complete list under the heading Plan Provider Information later in this document.

Plan Administrator:

Attention: Benefits Manager
Farella Braun + Martel LLP
One Bush Street, Suite 900
San Francisco, CA 94104
(415) 954-4400

Named Fiduciary:

Farella Braun + Martel LLP
One Bush Street, Suite 900
San Francisco, CA 94104
(415) 954-4400

**Agent for Service of Legal
Process:**

Plan Administrator

Farella Braun + Martel LLP
One Bush Street, Suite 900
San Francisco, CA 94104
(415) 954-4400

Service for legal process may also be made on the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage.

Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment. However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.**

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “Monthly” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical

benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth

in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the

Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

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

Women’s Health and Cancer Rights Act (WHCRA) of 1998

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

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

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

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Blue Shield Tandem PPO (HDHP/HSA)
- Blue Shield PPO (HDHP/HSA)
- Blue Shield Trio ACO HMO
- Blue Shield Access + HMO
- Kaiser HMO
- Kaiser Deductible HMO (HDHP with HSA)

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company.

The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

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

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a

result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Health Savings Accounts

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (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.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

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

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the 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 Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

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

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person

shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

- ☐ Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes
- ☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest \$1 or \$10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.
- ☐ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator²

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends ¹	To File a Claim, Contact:
Medical: HMO, Deductible HMO w/HSA	Kaiser Permanente Insurance Company Fully-Insured	28563	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Last day of the month in which you terminate employment	Claims Department PO Box 12923 Oakland, California 94604-2923 (800) 390-3510
Medical: Tandem PPO (HDHP/HSA), PPO (HDHP/HSA), Trio ACO HMO, Access+ HMO	Blue Shield Fully-Insured	W8000131	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Last day of the month in which you terminate employment	Blue Shield of California: P.O. Box 272540 Chico, CA 95927-2540 (855) 599-2650
Dental HMO, Dental PPO	Delta Dental Fully-Insured	22635 (PPO), 79748 (HMO)	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Last day of the month in which you terminate employment	Delta Dental P.O. Box 997330 Sacramento, CA 95899 (888) 335-8227 (PPO) (800) 422-4234 (HMO)
Vision	Vision Service Plan (VSP) Fully-Insured	112677	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Last day of the month in which you terminate employment	Member Services (800) 877-7195

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

² Please consult carrier documentation for further details regarding which family members are eligible to participate in each of the above coverages. For more information on eligibility and hours calculation please contact the Plan Administrator or Human Resources.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Employee Assistance Program (EAP)	CuraLinc Fully-Insured	N/A	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Last day of the month in which you terminate employment	For services: (888) 881-5462
Basic & Vol Life/AD&D, LTD	The Standard Life Insurance Fully-Insured	166681	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Date of termination or loss of eligibility	P.O. Box 2800 Portland, OR 97208-2800
Long Term Care	UNUM Fully-Insured	142407	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Date of termination or loss of eligibility	P.O. Box 100196 Columbia SC 29202
Business Travel Accident (BTA)	Zurich Fully-Insured	GTU 4220766	Employees who are regularly scheduled to work 17.5 hours or more per week	First day of month following or coinciding with the date of hire	Date of termination or loss of eligibility	P.O. Box 968041 Schaumburg, IL 60196 (866) 841-4771

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

² Please consult carrier documentation for further details regarding which family members are eligible to participate in each of the above coverages. For more information on eligibility and hours calculation please contact the Plan Administrator or Human Resources.

Appendix A: COBRA Continuation

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from:

Human Resources Department
Farella Braun + Martel LLP
One Bush Street, Suite 900 San Francisco, CA 94104
(415) 954-4400

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to eighteen (18) months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. The first page one of this notice provides the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if (i) any required premium is not paid on time, (ii) if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (Note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act), (iii) if a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or (iv) if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Farella Braun + Martel LLP of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. 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 Farella Braun + Martel LLP of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Farella Braun + Martel LLP of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses 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 employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee'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 the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

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 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the 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 that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Farella Braun + Martel LLP to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

Human Resources Department
Farella Braun + Martel LLP
One Bush Street, Suite 900 San Francisco, CA 94104

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 Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Farella Braun + Martel LLP Plan does not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown 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 as 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 Plan 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 claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to:

Human Resources Department
Farella Braun + Martel LLP
One Bush Street, Suite 900 San Francisco, CA 94104

If information is available about alternative coverage (coverage in lieu of continuation coverage, or individual conversion rights), it will appear here: NONE AVAILABLE

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from:

Human Resources Department
Farella Braun + Martel LLP
One Bush Street, Suite 900 San Francisco, CA 94104

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

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 the collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Department Clearance Officer, 200 Constitution Ave, N.W, Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from Farella Braun + Martel LLP About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Farella Braun + Martel LLP coverage **will not** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Farella Braun + Martel LLP Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Farella Braun + Martel LLP prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with Farella Braun + Martel LLP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Farella Braun + Martel LLP changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 01, 2024
Name of Entity/Sender:	Farella Braun + Martel LLP
Contact-Position/Office:	Benefits Manager/Human Resources
Address:	One Bush Street, Suite 900, San Francisco, CA 94104
Phone Number:	(415) 954-4748

Appendix C: Cafeteria Plan and FSA Provisions

During the Election Period prior to each Plan Year, each Participant shall be given the opportunity to elect which Benefit options he or she wishes to participate in. Those elections are irrevocable for the Plan Year, except as provided below and subject to Internal Revenue Code Consistency Rule requirements. You can change your elections only if you come forward within 30 days of an event described below (note the 60 day exception under item (b)). An Employee who elects not to participate for the Plan Year following the Election Period will generally have to wait until the next Election Period before again electing to participate in the Plan, except as provided below in item (b) and, subject to applicable facts and circumstances, items (e), (g), and (j).

- (a) **Changes in Status.** You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

- (b) **HIPAA Special enrollment rights.** Participants may change an election for major medical coverage (and any other non-excepted benefit) during a Plan Year and make a new election that corresponds with the special enrollment rights provided for under HIPAA including:

(1) Loss of health coverage.

(2) Acquisition of new dependent by marriage, birth, adoption, or placement for adoption.

(3) Loss of coverage due to loss of eligibility for Medicaid or CHIP.

(4) Eligibility for premium assistance under Medicaid or CHIP.

For items (3) and (4) individuals must request enrollment not later than 60 days after the loss of eligibility for Medicaid or CHIP or determination of eligibility for premium assistance.

- (c) **Qualified Medical Support Order.** In the event of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):
 - (1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
 - (2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.
- (d) **Medicare or Medicaid.** A Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) in Medicare or Medicaid, other than coverage consisting solely of the distribution of pediatric vaccines. If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan.
- (e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.
- (f) **Significant Coverage Curtailment.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- (g) **Addition or Significant Improvement of Benefit Package Option.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.
- (h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the

Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

- (i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.
- (j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant.
- (k) **Health FSA election cannot change due to a cost or coverage change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits as described above in items (e), (f), and (g).
- (l) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

- (1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and
- (2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Appendix D: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

Farella Braun + Martel LLP PRIVACY PRACTICES NOTICE

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to

get additional copies of this notice, please contact our Contact Office.

Contact Office: San Francisco, CA: Privacy Official

Telephone: (415) 954-4748

Fax: _____

E-mail: dmalliett@fbm.com

Address: One Bush Street, Suite 900 San Francisco, CA 94104

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the

Medical PPO & HMO

Dental

medical information of others they service, for the health care operations of their joint activities.

Vision

EAP/Mental Health

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 2024** and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the

medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your

permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family

member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of

others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services:

We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law,

and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request to the Human Resources Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we

will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and
2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on

behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint _____ to act on my behalf

[name of Authorized Representative]

or on behalf of _____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

☐ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

Claimant's signature

Date

Accepted: _____

Authorized Representative's signature

Date

Witness: _____

Witness signature

Date