corebridge financial

Plan Summary | Summary Plan Description

HealthSecure HRA®

A tax-advantaged program that funds pre-and post-retirement healthcare expenses.

Welcome! You are now an eligible participant in the HealthSecure Health Reimbursement Arrangement (HRA) plan. Please carefully review this Plan Summary/Summary Plan Description (SPD). It contains important information about how to utilize your HealthSecure HRA participant account(s). It also describes your rights as a participant in one or more of the health reimbursement arrangement (HRA) plans offered by HealthSecure HRA. This Plan Summary/SPD is updated from time to time. The most current version is available online after logging in at healthsecurehra.com.

This Plan Summary/SPD is intended to provide a summary of the Plan's benefits and the rules that apply regarding the availability of benefits. In the event of a discrepancy or conflict between this Plan Summary/SPD and your employer's actual plan document, your employer's plan document will control. Other than the Plan and Trust documents, the Plan Summary/SPD supersedes any previously published plan information materials.

Group health plans are required to furnish a standardized Summary of Benefits and Coverage (SBC) annually. The purpose of the SBC is to help consumers compare benefits across available insurance plans. While the HealthSecure HRA Plan is a group health plan, it is not insurance. Therefore, certain information and defined terms in the SBC do not apply. This Plan Summary/SPD is your best source for detailed Plan information. If you need a copy of the SBC, log in at healthsecurehra.com and click Resources. Printed copies are available upon request from the Customer Care Center (see contact information below).

Notice of legal process may be delivered to the Plan Administrator, the Trustee (if any), or your employer. By participating in the HealthSecure HRA Plan, you agree to the Terms and Conditions set forth within this Plan Summary/SPD under Part XI.

Your welcome letter confirms benefits eligibility and any limitations. You may also check with your employer if you have questions about which benefits and plan features are included in your plan.

Contents

Part I	Questions and answers	2
Part II	Plan information	5
Part III	Procedure for disputed claims	6
Part IV	Investment fund information	8
Part V	Premium Tax Credit and your HRA	8
Part VI	Coordination of benefits with Medicare and MMSEA Section 111 reporting	9
Part VII	Medicare Part D notice of non-creditable coverage	9
Part VIII	COBRA notice, USERRA rights and FMLA notice	10
Part IX	Privacy notice	11
Part X	Exemption from annual limit restrictions	14
Part XI	Terms & Conditions	14
Part XII	Definition of Dependent	15

Customer Care Center

1.888.364.5027
P.O. Box 4389, Clinton IA, 52733-4389
Online account access:
www.HealthSecureHRA.com

Plan administration services provided by:
HRA Administrator, LLC
221 N Wall St Ste 201, Spokane, WA 99201
1.800.888.8322

Part I

Questions and answers

What is the HealthSecure HRA Plan? The HealthSecure HRA Plan is a funded health reimbursement arrangement (HRA). Depending on your employer's plan design, your HRA plan assets may be held in a custodial account, in a voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) Section 501(c)(9), in a trust that is exempt from taxation based upon your employer's tax-exempt status under IRC Section 115 (a Section 115 trust), or, in some cases, a combination of these methods.

What is an HRA? An HRA or health reimbursement arrangement is a type of group health plan that reimburses qualified out-of- pocket medical care expenses and insurance premiums. All contributions, investment earnings, and reimbursements (claims) are tax-free.

The Internal Revenue Code defines an HRA as an arrangement that is funded solely by the employer and reimburses employees (participants) for medical care expenses incurred by the employee, the employee's spouse, and qualified dependents.

Contributions to an HRA are not subject to federal income tax or FICA tax. Investment earnings credited to an HRA sponsored by a governmental employer or held in a tax-exempt trust are not subject to federal income tax.

Reimbursements paid out as qualified medical expenses to participants, spouses, and qualified dependents are also excluded from tax. HRA contributions will not be reported on IRS Form W-2 from your employer. You do not report HRA contributions, earnings, or benefit payments (reimbursements) on your individual IRS Form 1040 federal income tax return either.

What is the difference between a VEBA trust and a Section 115 trust? Depending on your employer's plan design, assets in your HealthSecure HRA account(s) may be held in a VEBA trust, a Section 115 trust, or a combination of both. A VEBA is a non-profit, tax-exempt trust authorized under IRC Section 501(c) (9). A Section 115 trust is exempt from taxation based upon the tax exemption of your employer under IRC Section 115. Both forms of trust allow for tax-free accumulation of investment earnings on your HRA plan assets.

What is the Limited HRA Plan? The Limited HRA Plan is designed to provide limited forms of benefit coverage under the plan (Limited HRA coverage) based upon your employer's plan design, restrictions governed by federal law, or certain elections made by you as further described on page 3.
For information about Limited HRA coverage based upon your employer's plan design or restrictions governed by federal law, read, "Are there any restrictions?" on page 3.
For more information about Limited HRA coverage based upon elections made by you, read What is limited HRA coverage, and why might I need it?, on page 4.

Where can I find the forms I will need for my HRA plan? All the HRA forms you will need to file claims, change investment allocations, change personal information, and make other elections can be obtained from your benefits department, by logging into your account online at healthsecurehra.com, or from the Customer Care Center.

When and how can I get money out of my HRA account? Your eligibility to file claims depends on your employer's plan design. Some plans allow employees to begin filing claims while in-service, immediately after they enroll. Other plans require employees to separate from service or retire and be vested in all or a portion of their HRA before becoming eligible to file claims.

Your welcome letter (provided to you after you were enrolled) confirms your claims eligibility. If you are not immediately eligible to file claims, you will be notified when you do become eligible. Please check with your employer if you have questions about when you may become claims-eligible.

After becoming claims-eligible, and depending on the eligibility terms of your employer's plan, you may begin filing claims for qualified out-of-pocket medical care expenses incurred by you, your spouse, and any qualified dependents. You may file claims for any amount, but reimbursements are limited to your available HRA account balance. Eligible benefits will be paid until your HRA account is exhausted. Your employer's plan design, IRS rules, or certain elections made by you may limit dependent coverage, as well as when and what expenses may be reimbursed.

Claims payment is efficient and hassle-free. To expedite the process, you may sign up for direct deposit instead of waiting to receive paper check reimbursements in the mail. Automatic reimbursement of recurring qualified insurance premiums is also available.

Participant forms, including Claim Forms, Direct Deposit Enrollment Forms, and Automatic Premium Reimbursement Forms, are all available online after logging in to your account at healthsecurehra.com.

Whose expenses are eligible for reimbursement? After you become claims-eligible, you may begin filing claims for reimbursement of qualified expenses and premiums incurred by you, your spouse, and your qualified dependents, unless your employer's plan design limits dependent coverage. To understand who qualifies as a dependent, see Appendix A for our Definition of Dependent information.

What expenses are eligible for reimbursement? Eligible expenses generally include qualified medical, dental, and vision expenses (not covered by another source, such as your insurance plan or a flexible spending account) and premiums for medical, dental, or vision insurance or for Medicare premiums and expenses, and tax-qualified long-term care insurance. To be eligible for reimbursement, over-the-counter (OTC) medicines and drugs (except insulin and contact lens solution) must be prescribed by a medical professional or accompanied by a note from a medical

practitioner recommending the item or service to treat a specific medical condition. Eligible expenses are defined in Internal Revenue Code § 213(d). A list of common qualified expenses and premiums is available after logging in to your account at healthsecurehra.com.

IRS regulations provide that insurance premiums may not be reimbursed by your plan if they are (1) paid by an employer, (2) eligible to be deducted through an employer's Section 125 cafeteria plan, or (3) subsidized by the Premium Tax Credit. When requesting reimbursement of premiums deducted from your paycheck after tax, you should include a letter from your employer that confirms a pretax option for the deduction of such premiums is not available to you. Qualified premiums deducted from your spouse's paycheck after tax are eligible for reimbursement regardless of whether a pretax option exists for your spouse.

Qualified expenses that may be reimbursed from your HRA for you and your dependents will depend on your employer's plan design, IRS rules, or certain elections you may make to limit your HRA coverage. For example, some employer plan designs limit reimbursements to qualified insurance premiums only. Under certain circumstances (discussed later in this Section), expenses for your spouse and dependents may be limited based upon IRS rules imposed under federal law. Also, if you have elected limited HRA coverage (discussed later in this section), the types of expenses eligible for reimbursement are limited.

Are there any restrictions? Reimbursements (claims) may never exceed your available account balance at the time you file the claim. Depending on your employer's plan design, your account may be subject to vesting requirements or be limited to post-separation benefits only. Also, under certain circumstances, applicable law may require that claims for key employees be limited to qualified insurance premiums only.

Your welcome letter confirms your benefits eligibility and any restrictions on your account. You may also check as to whether your plan has any limitations on reimbursable expenses after logging in at heathsecurehra.com. Your claims eligibility status will be displayed in the Account Balance window on your home screen.

Some employers may contribute funds on your behalf to more than one account, and each account may be subject to different limitations as described above.

If your employer's plan requires you to separate from service before becoming fully claims-eligible (referred to as a "Post-separation Benefits" plan), IRS rules require that your claims eligibility be limited to reimbursement of expenses and premiums for dental, vision, and qualified long-term care ("Excepted Benefits") during any period that you are subsequently re-employed with the employer that made contributions to your HRA account. For some Post-separation Benefits plans, the employer's plan design may permit reimbursement for Excepted Benefits during active employment, while other employer Post-separation Benefits plans may not.

If you have an "In-service Benefits" HRA account (meaning your plan permits you to file claims for all Internal Revenue Code § 213(d) expenses incurred while you are still employed), spouse and dependent integration rules issued under federal law will apply. This means that certain expenses for your spouse and dependents may not be reimbursable while you are employed, unless your spouse and dependents are covered under a group health plan (GHP) at the time the expense is incurred. The spouse and dependent integration rules only apply if you are still working for the employer who contributed to your account. You must confirm GHP coverage for your spouse or dependent(s) on your claim form when you submit a claim. If your spouse or dependent(s) are not covered by a GHP, you can only use your HRA for their dental expenses and premiums, vision expenses and premiums, and tax-qualified long-term care expenses and premiums.

How do I use my Benefits Card? Your Benefits Card (debit card) can be used to instantly pay medical care expenses directly from your HRA. Be sure to save your supporting documentation, as the IRS requires us to make sure every transaction is for a qualified medical expense. Sometimes the electronic transaction data we receive from the merchant is not enough. We will let you know when we need additional details like an explanation of benefits (EOB) or detailed invoice from your medical provider. For more details about your Benefits Card, including frequently asked questions, log in at www.HealthSecureHRA.com and click the Resources tab.

How can I request another Benefits Card if I need one? To request an additional or replacement Benefits Card, log in at healthsecurehra.com, click **Benefits Card** on the menu bar, then click the **Manage Cards** button.

Are there any limits or restrictions on my Benefits Card? You must keep an account balance of at least $25 in your HRA or your card will not work. Additionally, you can spend up to 90% of your HRA balance every day (subject to a $5,000 daily limit).

What do I do if my Benefits Card transaction is declined or denied? A declined transaction is when the swipe at the merchant does not go through and your HRA account balance is not [charged/debited] for the transaction. A Benefits Card transaction may be declined by the merchant for a variety of reasons, including: (1) the merchant is not an approved medical care provider; (2) your account balance is insufficient; or (3) you are attempting to purchase items that are not approved as medical expenses. A **denied** transaction is when the debit card swipe has been approved at the merchant and deducted from your HRA account balance. However, the Plan is denying the transaction for some reason, most likely because additional supporting documentation is required or the documentation you provided is insufficient. Note that neither a declined transaction nor a denied transaction is considered a claim for purposes of filing an appeal under Part IV regarding Procedure for Disputed Claims. In order to initiate the

appeals process for a transaction that originated as a Benefits Card swipe, you must first file a claim for reimbursement of the expense.

What happens if I don't provide documentation when you ask me for it? Most of your Benefits Card transactions will be approved at the point of sale. In some cases though, the Plan will need additional documentation to verify the expense. IRS rules require the Plan to follow prescribed "pay-and-chase" rules if a participant does not submit sufficient documentation. Eventually, this may mean that we have to suspend your card, but don't worry! We'll give you plenty of time before that happens. The Plan will follow its applicable "pay-and-chase" rules, which may include, but are not limited to requesting that you reimburse the Plan for the amount that has not been verified, offsetting future reimbursement of claims by the amount not verified, and suspending your card. In some cases, the IRS requires the Plan to report the unverified amount as taxable income.

The OneBridge Visa® Benefits Card is issued by The Bancorp Bank N.A., pursuant to a license from Visa U.S.A. Inc. and may be used for qualified expenses wherever Visa debit cards are accepted. See Cardholder Agreement for details.

Can my HRA account automatically reimburse my insurance premiums? Yes. Simply submit a completed and signed Automatic Premium Reimbursement form with proper documentation. Based on your instructions, the Plan will reimburse insurance premiums from your account on an automatic basis. Direct deposit of reimbursements is available and recommended. Read "What expenses are eligible for reimbursement?" on page 2 for restrictions that may apply to reimbursement of premiums.

What happens if my claim for reimbursement is denied? If your claim for reimbursement of expenses is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims are discussed in Part III of this document.

What is a health savings account (HSA), and can I contribute to an HSA? An HSA is a type of tax-favored medical reimbursement account that differs from an HRA. Your HealthSecure HRA Plan is an HRA, not an HSA. If you want to make contributions to an HSA, you must meet the contribution eligibility requirements. HSA eligibility requirements are contained in IRS Publication 969 at www.irs.gov or www.ustreas.gov.

Can I have both an HRA and an HSA? Yes, you can have an HRA and an HSA, though certain rules apply. You can use either your HRA (if claims-eligible) or HSA to reimburse your qualified expenses, but note that most of your premiums incurred prior to age 65 are not reimbursable under an HSA (there are no ordering rules regarding which account must pay first). However, if you have a claims-eligible, HRA, current IRS rules require that you limit that HRA coverage if you want to make or receive contributions to an HSA.

To limit your HRA account, simply submit a Limited HRA Coverage Election form. You can get a copy online at healthsecurehra.com after logging into your account. Keep in mind that limiting your HRA account is not the only HSA contribution eligibility requirement.

What is limited HRA coverage, and why might I need it? Limited HRA coverage is an election that limits the types of expenses and premiums eligible for reimbursement from your HRA. You may want to limit your HRA account if: (1) You are a current employee and you, your spouse, or a dependent have Medicare coverage that you want to be primary to your HRA coverage; (2) You, your spouse, or a dependent would like to be eligible to make or receive contributions to a health savings account (HSA); or (3) You, your spouse, or a dependent want to become eligible to receive a Premium Tax Credit through a marketplace exchange.

HSA coordination. Limiting your HRA plan coverage is one of the requirements you must meet in order to become eligible to contribute to an HSA. Please see the questions earlier in this section for more information on HSA eligibility requirements. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for HSA coordination purposes: Dental (including orthodontia); Qualified high-deductible health plan (HDHP) premiums; and Vision.

Medicare coordination. If you have a claims-eligible HRA and still work for your contributing employer, Medicare Coordination of Benefits rules may require your HRA to pay first. If you are retired or separated from your HRA contributing employer, the Medicare Coordination of Benefits rules will not apply to your HRA account. Read Part VI for more information about your HealthSecure HRA account and Medicare. If Medicare Coordination of Benefits rules do apply to your HRA account, you may limit your HRA account until you separate from service so that Medicare instead pays first. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Medicare coordination purposes: Dental (including orthodontia); Vision; and Premiums for Medicare and Medicare supplement policies.

Premium tax credit eligibility. For any month that you are claims-eligible and have a positive account balance in your HRA account, you may not qualify for the Premium Tax Credit unless you take certain action. Please refer to Part V for more information. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Premium Tax Credit eligibility purposes: Dental (including orthodontia); Qualified long-term care (subject to IRS limits); and Vision.

To elect limited HRA coverage, simply submit a completed Limited HRA Coverage Election form. Forms are available online after logging in to your account at healthsecurehra.com. If you have any questions, please contact the Customer Care Center.

What happens if I get divorced? In the event that you become divorced or legally separated, your account may be split as part of a divorce decree, court order, or similar agreement. Coverage for an ex-spouse is taxable. Contact the Customer Care Center for more information.

What if I pass away before I use up my HRA account? If you pass away with a vested, positive account balance and you are survived by a spouse or qualified dependents, your spouse and/or dependents may submit claims for medical expense reimbursements until your account is exhausted. In the unlikely event you pass away with an unused account balance and have no eligible survivors, the executor of your estate can spend down your account by filing claims for any unreimbursed medical care expenses you may have incurred prior to your death. Any funds remaining after all final claims have been reimbursed would then be forfeited and re-contributed per the terms of your employer's HealthSecure HRA Plan document or otherwise applied as directed by your employer. IRS rules do not permit the payment of benefits to non-dependent heirs or beneficiaries under your plan.

Is my HRA account vested? That depends upon your employer's policy or collective bargaining agreement, whichever is applicable. Please check with your employer to find out if a vesting schedule applies to your HRA.

For post-separation HRA plans subject to vesting, your employer will notify the Plan when you separate from service and confirm whether you are partially or fully vested. The Plan will then notify you of any vested amount that is available to reimburse claims for qualified expenses.

How are my HRA funds invested? You may invest your HRA account using any combination of the available investment funds. You may change your investment allocations as often as once per calendar month after logging in to your account online at healthsecurehra.com, or by submitting a completed and signed Investment Change form. An Investment Fund Overview with investment performance history and fund objectives is available online and updated quarterly. In addition, you may view up-to-date fund fact sheets and prospectuses on the fund websites, which are listed on the Investment Fund Overview.

Will I receive a statement of my HRA account? Yes. Participant account statements, which detail all of your account activity, are provided quarterly. If you are signed up for e-communication, you will receive quarterly email notifications as soon as your statements are available for online viewing. If you are not signed up for e-communication, paper statements will be mailed to your address on file. You may contact the Customer Care Center to request copies of your statements at any time.

Can I view my HRA account information online? Yes. You may view your personal account information online after logging in to your account at healthsecurehra.com. Information available online includes account details and preferences, investment performance, contribution and claims history, and participant forms. You can also set up an automatic premium reimbursement, update account preferences, and update your personal information (name, address, etc.).

What are the Plan expenses, and how are they paid? Plan expenses include costs for the following services: plan administration, consultant, attorney, printing of plan forms, annual audit, bank and custodial, investment management, postage, etc. These Plan expenses are paid by fee deductions from participant accounts. The fees may vary from employer to employer and, as of the effective date of the Plan Summary/SPD, will generally range from $24 to $36 per year per participant account, plus 0.95% of assets on an annualized basis. Any applicable per participant account fees will be reflected on your quarterly account statement.

Certain fees, taxes or other assessments payable to the federal government under healthcare reform law may also be deducted from participant accounts. Investment management costs and other fund expenses are based on the fund(s) selected. Please refer to the Investment Fund Overview to review these expenses.

Who is the trustee of the Plan? Although it is not always legally required, most employers offering a HealthSecure HRA have established a tax- exempt trust to hold plan assets. The employer may serve as the trustee, or may appoint a third party to act as trustee. Please check with your employer to confirm whether a trust has been established, and if so, who will serve as the trustee of the Plan.

Is there a custodian or transfer agent for the Plan? Washington Trust Bank is the custodian/transfer agent for the Plan to hold title to assets on behalf of the Plan, execute investment trades as requested, and perform periodic valuations of the Plan's assets.

Who is responsible for developing and managing the Plan? HRA Administrator, LLC (HRAA), a subsidiary of The Variable Annuity Life Insurance Company (VALIC), provides plan administration services. HRAA is responsible for developing and managing the Plan and has engaged a team of seasoned service providers to perform certain administrative roles.

How do I find out more about the Plan? If you currently have an account and would like information regarding your account or about filing a claim, please contact the Customer Care Center. For other plan information, please contact your local financial professional.

Plan service providers

Customer Care Center
PO Box 4389,
Clinton, IA 52733-4389
1.888.364.5027

Local service, enrollment, and plan education:
Corebridge Financial
1.800.426.3753

Plan administration services provided by:
HRA Administrator, LLC
221 N Wall St Ste 201
Spokane, WA 99201

Part II

Plan information

The name of the Plan is the HealthSecure HRA Plan ("Plan").

The assets of the Plan are held in a custodial account with Washington Trust Bank.

Washington Trust Bank Attn: Private Banking
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

Depending on your employer's plan design, your HRA plan assets may be held in a non-trusteed custodial account, in a voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) Section 501(c)(9), or a trust that is exempt from taxation based upon your governmental employer's tax-exempt status under IRC Section 115 (a Section 115 trust). If your plan assets are held in a trust, the employer may serve as the trustee, or may appoint a third party to act as trustee. Please check with your employer to confirm whether a trust has been established, and if so, who will serve as the trustee of the Plan.

The Plan Administrator is HRA Administrator, 221 N Wall St, Ste 201, Spokane, WA 99201.

Notice of legal process may be delivered to the Plan Administrator or Trustee.

This Plan is provided under collective bargaining agreements or employer policy. Because the benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

In the event that a vested, claims-eligible participant account remains inactive for a period equal to three years (or the applicable state unclaimed property forfeiture period if such period is less than three years), and during that time (1) there has been no communication from or account activity by the participant and (2) the Plan has received at least two delivery failures for written correspondence to the participant, then the balance in such participant account will be forfeited back to the Plan and applied as directed by written instructions from the participant's employer.

The Plan year is the 12-month period from January 1 through December 31 or as otherwise specified by your employer. Requests for benefits under the Plan must be made in writing to the Plan in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing to the Plan.

Part III

Procedure for disputed claims

If you have a question or complaint regarding how one of your claims was adjudicated, please reach out to the Customer Care Center. A Customer Service Representative is happy to look into your claim and address your questions or concerns. Our Customer Care Center is often able to help resolve the matter and alleviate any frustrations.

When must I receive a decision on my claim? You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. The 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you submit the additional information, the Administrator will notify you of the decision on your claim within 15 days after the date of receipt of such information. If you do not submit the additional information, the claim will be deemed to be denied immediately following such 45-day period. The notice from the Administrator requesting additional information may also contain a provisional denial of the claim in the event the additional information is not received within the 45-day period.

What information will a notice of denial of a claim contain? If your claim is denied, the notice you receive from the Administrator will include: (1) The specific reason or reasons for the denial and sufficient information to identify the claim involved, if any, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) Specific references to pertinent plan provisions or IRS rules and regulations on which the denial is based; (3) An explanation of your right to appeal the denial; (4) A description of any additional material or information necessary for you to perfect the claim or appeal the denial and an explanation of why such material or information is necessary; (5) An explanation of your right to review the claim file and to present additional evidence, comments or testimony as part of the appeals process; (6) A description of available internal appeals procedures, including

information regarding how to request an internal review of your denial and the time frame within which to submit such a request; and (7) An explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

If you do not receive an approval or denial of your claim within the initial time period for review of your claim, your claim will be deemed to have been denied.

Do I have the right to appeal a denied claim? Yes, you have the right to an internal appeal and, if applicable, an external review by an independent review organization.

Do I have to appeal a denied claim before I can go to court? You will not be allowed to take legal action against the Plan, your employer, the administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit, and a final external review decision does not prevent you from pursuing other state or federal law remedies if they are available.

Is there a deadline for requesting my internal appeal? Yes. Your internal appeal must be delivered to the Administrator within 180 days from the date you receive notice that your claim was denied or from the date your claim was deemed to be denied. If you do not file your internal appeal within this 180-day period, you lose your right to appeal.

How will my internal appeal be reviewed? Any time before the deadline to request an internal appeal, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Administrator. The Administrator is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator relies on, generates, or considers new or additional evidence in connection with its final internal adverse benefit determination, other than evidence you have provided to it, you will be provided with this information within 30 days after the date the Administrator received your request for internal appeal, and given a reasonable opportunity (15 days) to respond to the evidence or rationale before the due date for the Administrator's internal review decision. If you do not respond to the new or additional evidence or rationale considered in denying your claim within the time period permitted to respond, your claim will be deemed to have received a final internal adverse benefit determination immediately following such time period. The notice from the Administrator with such additional evidence or rationale may also contain a provisional final internal adverse claim determination in the event the additional information is not received within the specified time period.

The internal appeal determination will be conducted by someone who is not (1) the individual who made the original determination; or (2) an individual who is a subordinate of the individual who made the initial determination.

When will I be notified of the decision on my internal appeal? The Administrator must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

What information is included in the notice of the denial of my internal appeal? If you receive a final internal adverse benefit determination, the notice you receive from the Administrator will include: (1) The specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) A description of available external review procedures, including information regarding how to request an external review of the internal appeals decision and the time frame within which to submit such a request; and (3) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist you with the external review procedures.

If you do not receive an approval or denial of your appeal within the initial time period for review of your appeal, your appeal will be deemed to have received a final internal adverse benefit determination subject to external review.

Do I have the right to seek a review of a final internal adverse claim determination to an external third party? You have the right to an external review of the Administrator's denial of your internal appeal, unless the denial was based on your (or your spouse's or dependent's) failure to meet the Plan's eligibility requirements.

Is there a deadline for filing my request for external review? Yes. You must file your request for external review not later than the first day of the fifth month after you received notice from the Administrator of, or are deemed to receive, a final internal adverse benefit determination. If you do not file your request for external review within this period, you lose your right to external appeal. For example, if you received or are deemed to receive your final internal adverse benefit determination on January 3 of any year, you must request external review by June 1 of the same year (or, if that is not a business day, the next business day thereafter).

What is the process for my external appeal? Within five business days after receiving the external review request, the Administrator must complete a preliminary review to determine if: (1) You are covered under the Plan; (2) You provided all the information and forms necessary to process the external review; (3) You followed and exhausted the internal appeals procedures; and (4) The denial of your claim related to you (or your spouse or dependent) not meeting the

eligibility requirements under the Plan, as claim denials based upon a failure to meet eligibility requirements are not subject to external review.

Within one business day after completion of its preliminary review, the Administrator will provide you with written notice of the outcome of its review. If your request for external review is complete but the claim denial is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and you will be permitted to complete the request not later than the deadline for filing a request for external review, or 48 hours after your receipt of the Administrator's preliminary review notice, whichever is later.

If the Administrator receives a timely, completed, and eligible request for external review, the Administrator will assign an independent review organization (IRO) to review the claim and you will receive written notice from the IRO that your request is eligible for external review and has been assigned to such IRO.

You will have the right to submit additional information in writing to the IRO within 10 business days after the date you receive notice from the IRO and, if the IRO receives any additional information within 10 business days after you receive such notice, then (1) the IRO must consider the additional information in its external review, and (2) the IRO is required to forward the additional information submitted by you to the Administrator within one business day after the date the IRO receives the information.

Within five business days after the date the IRO receives the external review assignment, the Administrator is required to provide the IRO with all documents and information considered by the Administrator in making its decision to deny the claim and internal appeal.

Upon receiving from the IRO any additional information submitted by you, the Administrator may reconsider its previous decision. If the Administrator reverses its decision upon such review, it will notify you and the IRO within one business day after making its reversal, and the IRO must terminate its external review. The IRO is not bound by the prior decision of the Plan in making its external review decision.

When will I be notified of the decision on my external appeal? The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review.

What information will be included in the IRO's decision on my external appeal? The notice to you of the IRO's external appeal decision will include the following information: (1) A general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial; (2) The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision; (3) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards; (4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision; (5) A statement that the IRO's decision is binding, unless other remedies are available to you or the Plan under state or federal law; (6) A statement that judicial review may be available to you; and (7) Phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Is the external reviewer's decision binding? The external reviewer's decision is binding upon the parties but does not terminate or preempt your right or the Plan's right to pursue other state or federal law remedies. However, such remedies may or may not exist. Therefore, unless another legal right exists for your claim, the external reviewer's decision will be binding.

Part IV

Investment fund information

Investment risk. Accounts invested in stock or bond funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

You should periodically review your selected investment fund choice(s). If your investment objectives change, you should reevaluate your fund selection(s) and submit any changes to the Customer Care Center. Remember, there have been numerous loss periods in the past in these types of funds and there will be others in the future. Investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, you may determine that stock or bond investments are more suitable as longer-term investments rather than for short-term purposes.

Using multiple funds. You may have your HRA account allocated to a single fund, or any combination of two or more available funds.

Transfers. You may transfer among the funds once each calendar month. Transfers are effective within two to three business days of receipt of your request.

Reimbursements (claims). If you have multiple funds, reimbursements made from your account will be pro-rated, based on your fund allocation percentage on file with the Plan.

Investment funds. You may view information regarding the available investment funds, including performance and a link to each fund company's fund fact sheet and prospectus at healthsecurehra.com.

Additional information. You may view additional information regarding the funds (including performance, risk, holdings, management, fund prospectuses, etc.) on the internet at: Columbia US Treasury Index Z www.columbiathreadneedleus.com; Vanguard Funds www.vanguard.com; or American Funds www.americanfunds.com.

Investment advice. You are encouraged to seek advice regarding these investment funds from your personal financial professional. The Plan Administrator and Customer Care Center do not give investment advice.

Fund operating expenses. Fund operating expenses are deducted from fund assets and include management fees, distribution (12b-1) fees, and other expenses.

Part V

Premium Tax Credit and your HRA

You may qualify for the Premium Tax Credit (subsidy) if you or a family member purchase health insurance through a state or federal marketplace exchange (sometimes referred to as "Obamacare"). The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through an exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your out-of-pocket premium amount, or you can wait until you file your tax return.

If you purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit, you should know: (1) **Marketplace exchange premiums that are subsidized by the Premium Tax Credit cannot be reimbursed from your HRA**; and (2) You may not qualify for the Premium Tax Credit for any month during which you have a full-coverage HRA. If you have a full-coverage HRA, are claims-eligible, and have a positive HRA balance or are receiving ongoing HRA contributions, then it may make sense for you to either use up or limit your HRA, as described in more detail below. If you decide to take one of these actions, you should do so before taking the Premium Tax Credit in advance.

Important: Keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you cannot qualify for the Premium Tax Credit and you do not need to use up or limit your HRA: (1) You are eligible for coverage in an employer-sponsored group health plan that meets the affordability and minimum value requirements under federal healthcare reform law. (If you are not sure whether this applies to you, check with your employer.); (2) You are eligible for coverage under a governmental plan such as Medicaid, Medicare, CHIP or TRICARE; (3) Your total family income (including income from investments, retirement benefits, and Social Security) exceeds the maximum amount for eligibility for the Premium Tax Credit (400% of the federal poverty level); (4) You are married but do not file a joint tax return; or (5) You are claimed as a dependent on someone else's tax return.

What can I do if my full-coverage HRA is the only thing keeping me from becoming eligible for the Premium Tax Credit? If you are claims-eligible and your full-coverage HRA is the only reason you cannot qualify for the Premium Tax Credit, you may consider one of these two options: **(1) Using up your HRA before taking the Premium Tax Credit.** You do not have to take the Premium Tax Credit right away. You could first use up your HRA to reimburse your non-subsidized premiums (and any other qualified medical care expenses incurred since your claims-eligibility date). Then, you could begin taking the Premium Tax Credit in advance to lower your monthly premium, or wait and claim it on your tax return, but only for premiums you paid after using up your HRA. Keep in mind that, if you receive any additional HRA contributions after using up your balance, you will lose eligibility for the premium tax credit for any months during which you have (or had) a positive balance in your HRA. **(2) Electing limited HRA coverage.** If you elect limited HRA coverage, your HRA will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations). If you elect limited HRA coverage for Premium Tax Credit eligibility, you can switch your HRA back to full coverage for any period that you are not taking the Premium Tax Credit. Limited HRA coverage is designed as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal healthcare reform law. To elect limited HRA coverage, submit a Limited HRA Coverage Election form. To access paper forms, log in at healthsecurehra.com and click Resources

Consider your options carefully. You should consider your options carefully and seek advice from a tax professional. The best decision may vary depending on your individual circumstances, including the amount in your HRA compared to the Premium Tax Credit amount you could receive. Keep in mind that if you take the Premium Tax Credit without first using up or limiting your HRA as described above, you will likely not qualify for the Premium Tax Credit and may be required to pay it back when you file your tax return for the year.

Where can I get more information? This plan summary is intended to provide you with general information about the Premium Tax Credit and the options available to you under the HealthSecure HRA Plan. For more information, go to www.irs.gov and type "premium tax credit" in the search bar.

Part VI

Coordination of benefits with Medicare and MMSEA Section 111 reporting

If you are entitled to Medicare and are claims-eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare unless you have elected limited HRA coverage. For more information about electing limited HRA coverage, refer to Part I.

To comply with federal law you should file your claims in accordance with these primary and secondary payer rules if you have a claims-eligible HRA account and have not elected limited HRA coverage: (1) If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (2) If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (3) If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA plans for plan years beginning on or after October 1, 2010, requires the Plan to report specific information about your HRA account to CMS (Centers for Medicare and Medicaid Services) unless you have either elected limited HRA coverage or certain other exceptions apply. For more information about electing limited HRA coverage, refer to Part I.

To comply with this federal law, the policies and procedures of the Plan will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims under your HRA account. In addition, in submitting claims for reimbursement or coverage under your HRA account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact the Customer Care Center or you can call the Medicare Coordination of Benefits Contractor at 1.800.999.1118. TTY users should call 1.800.318.8782.

Part VII

Medicare Part D notice of non-creditable coverage

To participants, spouses and dependents eligible or becoming eligible for Medicare: Important notice regarding your prescription drug coverage under this plan and Medicare Part D. Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006. You may have heard about Medicare's prescription drug coverage and wondered how it will affect you. Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage. Prescription drug coverage provided by this plan is limited to your available account balance and is considered non-creditable. In other words, coverage provided by this plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. The Plan is required to give you this notice to ensure you carefully consider your options, including potentially enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll. Generally, you can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year during Medicare's open enrollment, which is usually on or around October 15 to December 7. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, or qualified dependents are currently Medicare eligible, you need to make a decision. The terms of this plan will not change if you choose to enroll in a Medicare prescription drug plan. This plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources. More detailed information about Medicare plans that offer prescription drug coverage is contained in the Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by: (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for telephone numbers); or (3) calling 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1.800. 772.1213 (TTY 1.800.325.0778).

Note: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at any time from the Customer Care Center.

Part VIII

COBRA notice, USERRA rights and FMLA notice

COBRA NOTICE: Important information regarding COBRA continuation coverage rights for all participating employees, spouses, and covered dependents.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides eligible participants and those covered by this plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered dependents should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the Plan's Customer Care Center.

General information. A qualifying event is an event resulting in the loss of continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as qualified beneficiaries. Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or qualified beneficiary is required to notify the Plan within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage.

Qualifying events. If you are a **participating employee**, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you experience a reduction in hours affecting eligibility. If you are the **spouse** of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: **(1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) you become divorced or legally separated from employee; or (4) employee passes away. Qualified dependents** of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: **(1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) employee and spouse become divorced or legally separated; (4) child reaches age limitation or no longer meets the definition of qualifying child; or (5) employee passes away.**

Qualifying event notification. The Plan will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits. When the qualifying event is due to an active participating employee's voluntary or involuntary termination (other than for gross misconduct), reduction of hours of employment affecting eligibility, or death, then, the employer must notify the Plan within 30 days of the occurrence of such event. All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the Plan within 60 days of the occurrence of such event, using the COBRA Event Notice form. The Notice must be mailed or hand delivered to the Plan, and is available upon request upon calling 1.888.364.5027. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation and additional documentation may be required. If the Notice is late, incomplete, or is not submitted as outlined in the Notice of Procedures provided on the aforementioned form, no qualified beneficiary may be offered the opportunity to elect COBRA coverage.

COBRA continuation period. The COBRA continuation period is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA. COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's voluntary or involuntary termination (other than for gross misconduct) or reduction of hours of employment affecting eligibility. A maximum of up to 36 months is allowed when the qualifying event is due to a participating employee's legal separation or divorce, death, or when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension. If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the Plan within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period. Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of a qualifying child), or death, the covered spouse and/or covered dependents may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the Plan within 60 days of the occurrence of the second qualifying event.

Information resources. Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the Plan's Customer Care Center, or you may visit www. dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA rights. If you are on military leave that is governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the Plan's Customer Care Center.

FMLA notice. The HealthSecure HRA Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your HealthSecure HRA account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave. For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1.866.4US.WAGE (1.866.487.9243) or visit www.wagehour.dol.gov.

TRICARE: Understatutory amendments enacted in 2006, and final regulations issued in 2010, employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under the military's healthcare program, known as TRICARE. In particular, employers are prohibited from providing financial or other incentives for TRICARE-eligible employees not to enroll (or to terminate enrollment) under a group health plan that would (in the case of such enrollment) be a primary plan. Due to these federal regulations, if you are a TRICARE-eligible employee, your employer may be required to direct your contributions to an HRA with post-separation benefits (claims-eligibility) only. HealthSecure HRA Plan coverage is not primary to your employer's group health plan.

Part IX

Privacy notice

This Privacy Notice (the "Notice") describes the legal obligations of HealthSecure HRA (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, PHI is health information, including demographic information, collected from you or created or received by the Plan from which it is possible to individually identify you and relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of healthcare to you; or (3) the past, present, or future payment for the provision of healthcare to you.

Questions about this Notice or our privacy practices should be directed to the Plan's Customer Care Center at 1.888.364.5027.

Who will follow this Notice? The Plan and any service providers that assist in the administration of Plan claims are required by law and by contract with the Plan to follow this Notice. A record of your healthcare claims reimbursed under

the Plan is kept for administration purposes only. This Notice applies to all medical records we maintain.

Effective date. This Notice is effective February 15, 2026.

Privacy pledge – our responsibility. We are required by law to (1) make sure PHI identifying you is kept private; (2) give you certain rights with respect to your protected health information; (3) provide this Notice of our legal duties and privacy/security practices concerning protected health information about you; and (4) follow the terms of the Notice currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make a material change to the Notice, we will provide you with a copy of our revised Privacy Notice by posting the updated Notice on the Plan website, and include information about the revised Notice and how you can obtain it in your next eligible participant account statement delivery.

How we may use and disclose PHI about you. The following categories describe various ways we use and disclose PHI. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories: **(1) For payment (as described in applicable regulations)**. We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from healthcare providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your healthcare provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share PHI with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments. **(2) For healthcare operations (as described in applicable regulations)**. We may use and disclose PHI about you for other Plan operations necessary to run the Plan. For example, we may use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. **(3) To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. **(4) As required by law.** We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action. **(5) To avert a serious threat to health or safety.** We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician. **(6) To Employers or Plan Sponsors.** For the purpose of administering the Plan, we may disclose PHI to certain employees of your Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special situations. In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. **(1) Military and veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority. **(2) Workers' compensation.** We may release PHI about you for workers' compensation or similar programs providing benefits for work-related injuries or illness. **(3) Public health risks.** We may disclose PHI about you for public health activities such as to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law). **(4) Health oversight activities.** We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws. **(5) Lawsuits and disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested. **(6) Law enforcement.** We may release PHI if asked to do so by a law enforcement official (a) in response to a court order, subpoena, warrant, summons, or similar process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct at the hospital; and (f) in emergency

circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime. **National security and intelligence activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required disclosures. The following is a description of disclosures of your PHI we are required to make:
(1) Government audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
(2) Disclosures to you. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your healthcare benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or healthcare operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other disclosures. (1) Personal representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative. **(2) Spouses and other family members.** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your rights regarding PHI about you"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.
(3) Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights regarding PHI about you. You have the following rights regarding PHI we maintain about you. **(1) Right to inspect and copy.** You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to the Customer Care Center. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed. **(2) Right to amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the Customer Care Center including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement. **(3) Right to an accounting of disclosures.** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (a) disclosures for purposes of treatment, payment, or healthcare operations; (b) disclosures made to you; (c) disclosures made pursuant to your authorization; (d) disclosures made to friends or family in your presence or because of an emergency; (e) disclosures for national security purposes; and (f) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Customer Care Center. Your request must state the time period

you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. **(4) Right to request restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, healthcare operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. We will comply with any restriction request if (a) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or healthcare operations (and is not for purposes of carrying out treatment); and (b) the PHI pertains solely to a healthcare item or service for which the healthcare provider involved has been paid in full. To request restrictions, you must submit a written request to the Customer Care Center detailing (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply (i.e., your spouse). **(5) Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the Customer Care Center specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests. **(6) Right to be notified of breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI. **(7) Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, log in to your account at healthsecurehra.com or contact the Customer Care Center at 1.888.364.5027.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan's Privacy Official at (713) 831.6371. You will not be penalized or otherwise retaliated against for filing a complaint.

Substance Use Disorder Records. The Plan will not use or disclose your substance use disorder ("SUD") records in civil, criminal, administrative, or legislative proceedings against you unless the Plan receives (i) written consent or (ii) a court order, after you have been provided notice and an opportunity to be heard. A court order authorizing use and disclosure of your SUD records must be accompanied by a subpoena or other legal requirement compelling disclosure before the Plan can use or disclose such SUD records..

Other uses of PHI. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

Potential for Redisclosure. When your PHI is disclosed as described in this Notice, there is a potential it will be redisclosed by the person receiving the PHI and the PHI will no longer be subject to the protections described in this Notice and other applicable laws.

Part X

Exemption from annual limit restrictions

Current federal law generally prohibits health plans from applying annual or lifetime dollar limits on coverage for certain benefits.

Your HRA has been designed based upon exemptions from these annual and lifetime limit restrictions and in accordance with guidance issued by the Internal Revenue Service and the U.S. Department of Health and Human Services.

Accordingly, your HRA reimbursements (claims) are limited to your available account balance. This means coverage provided to you by this Plan may not reimburse all of the out-of-pocket medical care expenses you may incur.

Part XI

Terms & Conditions

By enrolling and participating in the HealthSecure HRA Plan and taking any action with respect to your HRA benefits under the Plan, you agree to the following Terms & Conditions. You agree that the Plan and the parties involved in this Plan (including, but not limited to, the employer, your bargaining representative, the Plan Administrator, the Trustee, Plan service providers, and the agents of each, collectively referred to as the "Plan and its agents") cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any tax, charge, penalty, assessment, or other amount that is determined to be attributable to or

allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan and its agents harmless with respect to such withholding or any failure to withhold or pay such amounts and any other actions taken in good faith for the operation of the Plan. You understand that for proper administration of the Plan and compliance with applicable law, you must provide true and accurate information to the Plan and regularly confirm and update your enrollment information, including name, address, phone number, dependents, and Social Security numbers for yourself and your dependents.

Information submitted to the Plan fraudulently may result in adverse tax consequences or penalties and/or your termination from the Plan. You also understand that it is your responsibility to review each statement to confirm that there are no investment or financial errors reflected on your account. Any errors must be reported by you to the Plan within ninety (90) days after the error is first viewed by you online or first reflected in a statement or other written information delivered to you by the Plan and its agents.

E-communication Terms & Conditions. For your e-communication election to be effective, you must provide the Plan with your email address. The electronic documents you will receive include e-statement notifications and newsletters, claims processing notifications and other important Plan information. Please note the following: (1) You may withdraw your consent for electronic documents at any time at no charge; (2) To update your e-communication election or email address, please log in to healthsecurehra.com and click on My Profile; (3) It is your responsibility to keep your email address current with the Plan. If your electronic documents are returned to the Plan due to an undeliverable email address, the Plan may remove your e-communication election; (4) Any electronically delivered documents will not be mailed to you by U.S. Mail; (5) You can view and print copies of your electronic documents or request paper copies (at no charge) from the Customer Care Center; and (7) You will need Adobe Acrobat Reader software loaded on a computer in order to access electronic documents. A free copy of Adobe Acrobat Reader is available at www.adobe.com.

Part XII

Definition of Dependent

Your spouse and dependents are eligible for coverage under your health reimbursement arrangement (HRA). Dependents must meet the definition of Qualifying Child or Qualifying Relative. These requirements are defined by Internal Revenue Code Sections 105(b) and 152.

A Qualifying Child is someone who: (1) Is the participant's son or daughter, stepchild, foster child, **is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico and is either:** (a) age 26 or younger at the end of the calendar year in which expenses were incurred; or (b) permanently and totally disabled; or (2) Is a brother, sister, stepbrother, stepsister, or a descendent of the participant's son, daughter, stepchild or foster child and is either: (a) under age 19; or (b) under age 24 and a full-time student; or (c) permanently and totally disabled and is younger than the participant, lives with participant for more than half the year, does not provide more than half of his or her own support, will not file a joint tax return for the year in which the expense was incurred and is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

A **Qualifying Relative** is someone who: (1) Is the participant's (a) son, daughter, stepchild, foster child, or a descendant of any of them (for example, a grandchild); or (b) brother, sister, or a son or daughter of either of them; or (c) father, mother, or an ancestor or sibling of either of them (for example, the participant's grandmother, grandfather, aunt, or uncle); or (d) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or (e) any other person (other than the participant's spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and (2) Will not be a qualifying child (see Qualifying Child above) of any other person as of the last day of the calendar year in which expenses were incurred; and (3) For whom the participant provided over half the support for the calendar year; and (4) Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

Qualifying Child of Divorced or Separated Parents. A participant's child is treated as the dependent of both parents for the purposes of health plan coverage if during the calendar year in which expenses were incurred: (1) the participant's child is in the custody of the participant or their other parent for more than half the year; (2) the participant's child receives over half of his or her support during the year from the participant or their other parent.

Domestic Partners. Unless your domestic partner qualifies as a legal spouse under state law, a domestic partner must meet all of the Qualifying Relative requirements to be eligible for coverage under your HRA. If you need to list your domestic partner as a dependent, please give us a call.

Step into the future you've imagined

At Corebridge Financial, we believe everyone deserves financial security. Every day, we work hard to make it possible for more people to take action in their financial lives—because action is the bridge from planning to outcomes, from today's financial needs to tomorrow's aspirations.

Our goal is to help you feel confident about your future.

corebridgefinancial.com/retire 1.888.569.7055

This material is general in nature, was developed for educational use only, and is not intended to provide financial, legal, fiduciary, accounting or tax advice, nor is it intended to make any recommendations. Applicable laws and regulations are complex and subject to change. Please consult with your financial professional regarding your situation. For legal, accounting or tax advice consult the appropriate professional.

Securities and investment advisory services offered through VALIC Financial Advisors, Inc., member FINRA, SIPC and an SEC-registered investment adviser.

VALIC Retirement Services Company provides retirement plan recordkeeping and related services and is the transfer agent for certain affiliated variable investment options.

All companies above are wholly owned subsidiaries of Corebridge Financial, Inc.

Corebridge Retirement Services, Corebridge Financial and Corebridge are marketing names used by these companies. Learn more about our affiliated companies: corebridgefinancial.com/names.

© Corebridge Financial, Inc. All rights reserved.

VC 19086 (04/2026) J1918503 EE

corebridge financial