2025 Benefits Handbook

Salaried, Full-time & Part-time Hourly Associates

TRANSFORMCO

About This Handbook

Transform Midco LLC ("Transform" or the "Company") provides a comprehensive and competitive benefits program designed to meet the needs of Associates and their families. This Benefits Handbook (the "Handbook") provides a detailed description of the Transform Health and Welfare Plan (the "Plan"). Use it as reference when you have specific benefits questions.

The information in this Handbook is effective January 1, 2025, except as otherwise noted. This Handbook, the certificates and documents incorporated by reference (if applicable) and any summaries of material modifications distributed after January 1, 2025 constitute the most current summary plan description ("SPD").

Nothing in this Handbook should be interpreted as a contract or guarantee of employment. Transform retains the right to modify, amend, suspend or terminate the Plan or any of its benefit programs at any time. If the information provided in this Handbook differs from the terms of the legal documents governing the Plan, the legal documents govern.

Important Note

The benefits described in this Handbook are available to all eligible, salaried Associates and hourly Associates, except for those businesses or Associate groups that do not participate in certain benefits or have different benefit provisions, including but not limited to:

Associates in	Benefits that are different from what is described in this Handbook
Kmart Distribution Centers	• Eligibility for Benefits
California	• Short-term Disability
New Jersey, New York and Rhode Island	• Short-term Disability
Hawaii	• Eligibility for Benefits • Short-term Disability
Guam and the Virgin Islands	• Eligibility for Benefits
Puerto Rico	• Medical • Commuter Benefits • Dental • Short-term Disability • Flexible Spending Accounts

Ayuda

La Compañía proveerá ayuda a aquellos empleados que puedan tener dificultad en comprender este folleto en inglés. Si necesita ayuda, consulte con su gerente de unidad o su representante de Recursos Humanos.

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INTRODUCTION

OVERVIEW OF YOUR BENEFITS

Transform offers a variety of benefits designed to meet your and your family's needs. You may be eligible to take advantage of programs providing health care coverage, disability and survivor protection, savings opportunities, merchandise discounts and educational assistance.

The benefit programs described in this Handbook apply to eligible full-time hourly Associates, part-time hourly Associates, full-time salaried Associates, and part-time salaried Associates of Transform and the participating employers. You are an hourly Associate if you are paid at an hourly rate. You are a salaried Associate if you have a base salary that generally is not affected by the number of hours you work. For purposes of this Handbook, all references to "salaried" include both full-time and part-time Associates (unless noted otherwise). Benefits differ for certain business units or locations.

In addition to the Handbook, you can also get plan information online through **www.88sears.com**, anytime, anywhere. You can get *personalized* information about your benefit options and contributions, as well as general information about the Plan and how it works, through the links provided on **www.88sears.com**. A variety of online tools are also available to help you take full advantage of the Plan.

Enrolling in your benefits is easy and convenient. You can enroll through a secure Web site, **www.88sears.com**. Enrollment information can be found in the chart below and in the *Enrolling in the Plan* section.

The eligibility requirements within this Handbook take precedence over eligibility requirements included in any documents provided to you by the various insurers offered through the Plan.

WHEN ARE YOU ELIGIBLE?

You participate in some benefits right away. For others, you're generally eligible within 90 days or one year of your hire date. See the following charts for the eligibility requirement for each benefit plan. For part-time hourly Associates, as required by the Affordable Care Act (ACA), there are additional special rules related to eligibility for Medical Program coverage. These are generally explained below.

MEDICAL PROGRAM — SPECIAL ELIGIBILITY RULES FOR PART-TIME HOURLY ASSOCIATES

In accordance with the ACA, Transform offers Medical Program coverage to part-time hourly Associates who average 30 or more "hours of service" a week over either the Associate's initial measurement period or the companywide measurement period. The measurement periods are the following periods:

- Initial measurement period: A newly hired Associate's first eleven (11) months of employment, starting with the date of hire.
- Companywide measurement period: November 1 through the following October 31, adjusted for payroll periods.

Generally, an hour of service is an hour actually worked or an hour for which an Associate was paid (such as vacation or time on leave).

If you average 30 or more hours of service during your initial measurement period, you will be offered Medical Program coverage for a 12-month period, beginning after a sixty (60) day administrative period, during which you will be notified of your eligibility date and how to elect coverage. You will also remain eligible for coverage through the end of the plan year in which such 12-month period ends.

If you were employed as of the first day of companywide measurement period, you are an ongoing Associate and your eligibility is based on your hours of service during the companywide measurement period. So, if you average 30 or more hours of service during the companywide measurement period, you generally will receive and Enrollment Notice in November, which will describe to you how coverage is elected for the upcoming plan year (calendar year).

In all events, if you become eligible for and elect coverage, you must comply with the terms of the Medical Program including, but not limited to, the requirement that you pay your share of the cost of coverage.

Each year, Transform will evaluate hours to determine whether you qualify for coverage under the Medical Program's measurement period rules.

Special rules apply if you have a break in service, take a leave of absence, or change your job classification. For questions regarding Medical Program eligibility, contact the Plan Administrator.

Benefit Programs	Eligibility Date	Enrollment
▪ Medical Program ▪ Dental Program ▪ Vision Program ▪ Health Care and Dependent Care Flexible Spending Accounts (FSAs) ▪ Health Savings Account (HSA)	**Full-time hourly:** After 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Part-time hourly – Medical, Health Care Flexible Spending Account (FSA) and Health Savings Account (HSA):** January 1 following your enrollment, if eligibility is due to your hours of service during the companywide measurement period (each November 1 to October 31); or the date specified in your Enrollment Notice, if eligibility is due to your hours of service during your initial measurement period (first 11 months of employment). **Part-time hourly – Dental, Vision and Supplemental Medical:** January 1 following enrollment period if working an average of 20 or more hours per week, date of transfer to an eligible class, or date specified in Enrollment Notice. **Salaried:** On date of hire as a salaried Associate.	You may enroll within 31 days of your hire date by visiting **www.88sears.com**. All Associates must enroll within the first 31 days of employment regardless of the benefit effective date. Part-time hourly Associates will receive an Enrollment Notice specifying both the enrollment period and the date that coverage would take effect. ***Please note***: If you do not enroll in the Medical Program, Dental Program, Vision Program or Health Care and Dependent Care Flexible Spending Accounts, as applicable, within 31 days of becoming eligible, you will have to wait until the next annual enrollment period (held each fall) to enroll, unless you experience a qualified change in status (described later in this section and in the *Other Information* section).
▪ Company Paid Life Insurance Program	**Full-time hourly**: After 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Salaried**: On date of hire as a salaried Associate.	You are automatically enrolled once you become eligible.
▪ Optional Life Insurance Program	**Full-time hourly**: After 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Part-time hourly:** January 1 following enrollment period if working an average of 20 or more hours per week, date of transfer to an eligible class, or date specified in Enrollment Notice. **Salaried**: On the first day of the month after date of hire.	You may enroll within 31 days of your hire date by visiting **www.88sears.com**. All Associates must enroll within the first 31 days of employment regardless of the benefit effective date. Part-time hourly Associates will receive an Enrollment Notice specifying both the enrollment period and the date that coverage would take effect. ***Please note***: If you do not enroll in Optional Life Insurance within 31 days of becoming eligible, you will need to submit a completed evidence of insurability questionnaire to the insurance company if you want to enroll at a later date.
▪ Short-term Disability (STD) Program	**Full-time hourly**: After 90 days of employment. Associates in certain business units or locations may be eligible sooner. **Salaried**: On date of hire as a salaried Associate.	You do not need to enroll.

Benefit Programs	Eligibility Date	Enrollment
▪ Long-term Disability (LTD) Program	**Full-time hourly**: After 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Salaried:** On the first day of the month after date of hire.	**Full-time hourly:** You may enroll within 31 days of your hire date by visiting www.88sears.com. All Associates must enroll within the first 31 days of employment regardless of the benefit effective date. **Salaried**: You are automatically enrolled. You may elect to drop coverage at any time. **Both**: If you do not enroll in LTD coverage within 31 days of becoming eligible, you will need to submit a completed evidence of insurability questionnaire to the insurance company if you want to enroll at a later date.
▪ Accident Insurance Program ▪ Critical Illness Insurance Program ▪ Hospital Indemnity Insurance Program	**Full-time hourly**: First of the month after 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Part-time hourly:** January 1 following enrollment period if working an average of 20 or more hours per week, date of transfer to an eligible class, or date specified in Enrollment Notice. **Salaried:** On date of hire as a salaried Associate.	Part-time hourly Associates will receive an Enrollment Notice specifying both the enrollment period and the date that coverage would take effect. You may enroll within 31 days of your hire date by visiting **www.88sears.com**. All Associates must enroll within the first 31 days of employment regardless of the benefit effective date.
▪ Everyday Marketplace	**Full-time hourly:** After 90 days of employment. **Part-time hourly:** Eligible for limited benefits if working an average of 20 or more hours per week, date of transfer to an eligible class, or date specified in Enrollment Notice. **Salaried:** On date of hire as a salaried Associate. **New Hire Part-time hourly**: Eligible for limited benefits after 90 days of employment; average hours calculated on an annual basis.	Visit https://everyday.aon.com/transformco Before enrolling in benefits on Everyday Marketplace, you will first need to create your Everyday Marketplaceaccount.
▪ Whole Life with Long Term Care (LTC)	**Full-time hourly**: After 90 days of employment for most Associates. Associates in certain business units or locations may be eligible sooner. **Part-time hourly:** Eligible if working an average of 20 or more hours per week, date of transfer to an eligible class, or date specified in Enrollment Notice. **Salaried**: On date of hire as a salaried Associate. **New Hire Part-time Hourly**: Eligible for limited benefits after 90 days of employment; average hours calculated on an annual basis.	You may enroll within 31 days of your hire date by visiting **www.88sears.com**. All Associates must enroll within the first 31 days of employment regardless of the benefit effective date. Part-time hourly Associates will receive an Enrollment Notice specifying both the enrollment period and the date that coverage would take effect. ***Please note***: If you do not enroll in Whole Life with LTC within 31 days of becoming eligible, you will need to submit a completed evidence of insurability questionnaire to the insurance company if you want to enroll at a later date.

Benefit Programs	Eligibility Date	Enrollment
▪ Business Travel Insurance Program ▪ Associate Discounts* ▪ Commuter Benefits Program ▪ WorkLife Solutions	**Full-time hourly:** On date of hire as a full-time hourly Associate or the date of transfer to full-time hourly status. **Part-time hourly – Business Travel Insurance, Associate Discounts, and WorkLife Solutions:** For the Business Travel Insurance Program and the Associate Discounts, on date of hire; for WorkLife Solutions, after one year of employment. **Salaried:** On date of hire as a salaried Associate.	To enroll for Commuter Benefits, visit **www.88sears.com**. You do not need to enroll in the Business Travel Accident Insurance Program or for Associate Discounts and WorkLife Solutions.* *Except for dependent children in an Associate Discount program. To enroll dependent children in the Associate Discount program for which you are eligible, you can call **1-888-887-3277, option 1**.
▪ Adoption Assistance Program	**Salaried & Full-time hourly:** Eligible after one year of service.	To enroll, call **1-888-887-3277, option 1** and choose the benefits option.

WHO IS ELIGIBLE FOR BENEFITS?

Your eligibility for benefits is based on your employment status. The benefit programs described in this Handbook apply to full-time hourly Associates and salaried Associates. Additionally, the Medical, Dental, Vision, Supplemental Medical, Optional Life Insurance, Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance. Business Travel Insurance, Associate Discounts and WorkLife Solutions benefit programs described in this Handbook apply to part-time hourly Associates. Please note eligibility may be based on average weekly hours.

ELIGIBLE DEPENDENTS

Your dependents may be eligible to take advantage of coverage under many of the benefit programs of the Plan. Except as otherwise indicated, your eligible dependents include:

- **Your legal spouse** (whether opposite or same-sex) other than common law spouses.

  If you divorce your spouse, your spouse is no longer eligible for benefits, even if you have a court order that states you are responsible for paying for your ex-spouse's health benefits. You must cancel your ex-spouse's coverage upon your divorce becoming final. Your spouse will be offered continuation of medical, dental, and/or vision coverage under COBRA. For more information on COBRA, refer to the *Other Information* section of this Handbook.

- **Your children** up to age 26.

- **A disabled child** who is incapable of self-sustaining employment because of a mental or physical disability may continue coverage at age 26 and beyond if the child was covered as an eligible dependent at the time he or she turned age 26.

  A disabled dependent age 26 or older may be added to medical, dental, or vision coverage if:

  - the disabled dependent was covered as an eligible dependent under another employer-sponsored group health plan at the time he or she turned age 26; and
  - the disabled dependent lost that coverage due to termination of employment of you or your spouse.

  In such cases, the dependent must be added to coverage within 31 days of loss of coverage or loss of COBRA coverage.

  In the event coverage is requested beyond age 26 due to your child being disabled, you will be required to provide satisfactory proof of disability.

ELIGIBLE DEPENDENT DEFINITIONS

Eligible dependents include your children and spouse. Eligible dependents do not include dependents engaged in full-time regular military service.

Your "children" are defined to include:

- Your natural children;
- Children you have legally adopted or children placed with you for adoption as of the date you are granted legal custody;
- Children for whom you are the legal guardian or have legal custody;
- Your step-children; and
- Children who are recognized under a qualified medical child support order (QMCSO) as having a right to enroll in a plan, provided you already are enrolled or enroll in the plan upon receipt of the QMCSO.

"Spouse" refers to your legal spouse.

Specific rules apply to dependent coverage under the following benefits:

Medical, Dental and Vision Programs

You may elect to cover your spouse and/or any or all of your eligible dependent children.

- You cannot be covered as an Associate and as a dependent at the same time.
- If both parents of any dependent child are covered as Associates, the child is considered a dependent of one parent only.
- Dependents cannot be covered unless the Associate is covered, and dependents must be enrolled in the same option as the Associate.

Associate Discounts

As a Transform Associate, you may be entitled to discounts on merchandise and services purchased from various Transform businesses. Refer to the *Associate Discount* section of the Handbook for more information.

Optional Life Insurance Program

You can choose to cover your spouse and/or your eligible dependent children.

- You cannot be covered as an Associate and as a dependent at the same time.
- Associates do not need to be enrolled in the Optional Life Insurance Program in order to cover their dependents.
- If both parents of any dependent child are covered as Associates, the child is considered a dependent of one parent only.
- You and your eligible dependents must be able to perform normal activities on both the date of enrollment and on the effective date of coverage.
- The amount of spouse coverage cannot exceed the amount of your coverage.
- A disabled child's coverage may continue beyond age 25 as a rider to adult Optional Life coverage. The dependent rider may remain in effect as long as the child remains dependent and disabled and the adult maintains coverage. The children's portability privilege is not available for a disabled child who continues coverage under this program. You must contact the Transform group life insurance provider to request continued coverage for a disabled child.

Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance

You can choose to cover your spouse and/or your eligible dependent children.

- You cannot be covered as an Associate and as a dependent at the same time.
- If both parents of any dependent child are covered as Associates, the child is considered a dependent of one parent only.
- A disabled child's coverage may continue beyond age 26 as long as the child remains dependent and disabled and the adult maintains coverage.

ENROLLING IN THE PLAN

Enrolling in your benefits is easy and convenient. Subject to the rules of each benefit program you can enroll or make changes virtually 24 hours a day, seven days a week (excluding scheduled system maintenance periods) by visiting the Transform HR Web site, **www.88sears.com**. Your personal information is protected by requiring you to enter your Social Security number and a password or personal identification number (PIN) before you can access certain types of information or perform certain transactions. Representatives are available at **1-888-887-3277, option 1** from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday, if additional assistance is needed.

Enrollment Period for Medical Program for Part-Time Hourly Associates

If you are a part-time hourly Associate and you become eligible for the Medical Program based on your hours of service during your initial measurement period (first 11 months of employment), your 31-day enrollment period will be specified in your Enrollment Notice.

If you become eligible for the Medical Program because of your hours of service during a companywide measurement period (52 week look back period based upon annual pay cycles), you will be offered an enrollment period that ends before the start of the next plan year.

Enrollment Period

Newly Eligible Associates and Dependents

See the chart at the beginning of this section for the timing of when you can enroll for benefits.

Annual Enrollment

Before the start of each benefit plan year, eligible Associates are offered the opportunity to enroll in, change or cancel medical, dental, vision and/or FSA coverage for the upcoming plan year. Unless you experience a qualified change in status (as described later in this section), you may elect to enroll, change or cancel coverage only during the annual enrollment period.

For all other benefits, you may enroll in, change or cancel coverage at any time after you become eligible.

When Coverage Begins

Associate Coverage

The date your coverage begins depends on when you enroll.

For medical, dental, vision and FSA coverage for full-time hourly and salaried Associates

- **If you are a newly eligible Associate and enroll:**
  - before your eligibility date — coverage begins on your eligibility date.
  - within 31 days after your eligibility date — coverage begins on the first day of the month on or after the date your enrollment is processed (for salaried Associates, coverage begins on their eligibility date).
- If you enroll **during an annual enrollment period,** your coverage choices are effective on the next January 1.
- If you enroll **within 31 days after a qualified change in status**, coverage begins on the first day of the month on or after the date your enrollment is processed. For medical coverage only: If you enroll within 31 days after the birth, adoption or placement for adoption of a child, coverage is effective on the date of birth, adoption or placement for adoption.

For medical, dental, vision, optional life insurance and supplemental medical coverage for part-time hourly Associates

- Part-time hourly Associates who become eligible based on their hours of service during a companywide measurement period will begin coverage as of January 1 following the enrollment period. Part-time hourly Associates who become eligible based on hours of service during their initial measurement period, coverage will begin as of the date specified in the Enrollment Notice.
- Medical Program coverage is offered to part-time hourly Associates who average 30 or more hours of service a week over either the Associate's initial measurement period or the companywide measurement period. Dental, Vision, Optional Life and Supplemental Medical Program coverage is offered to part-time hourly Associates who average 20 or more hours of service a week over the companywide measurement period.
- **For LTD and Optional Life Insurance coverage:**
  - **Full-time hourly LTD and Optional Life**: If you don't enroll when you are first eligible for LTD or Optional Life Insurance coverage, you can apply for coverage at a later date. Coverage begins on the first day of the month after the date the insurance company approves your application for coverage.
  - **Salaried LTD**: You are *automatically* enrolled in LTD coverage. Coverage is effective on the first day of the month after your date of hire as a salaried Associate. If you decline LTD coverage within 31 days of your date of hire, coverage will not take effect. If you decline LTD coverage when first eligible or drop coverage at a later date, you can apply for coverage at a later date. Coverage begins on the first day of the month after the date the insurance company approves your application for coverage.
  - **Salaried Optional Life**: If you don't enroll when you are first eligible for Optional Life Insurance, you can apply for coverage at a later date. Coverage begins on the first day of the month after the date the insurance company approves your application for coverage.
  - If you are not Actively at Work (as defined under the *Optional Life Insurance* section of this Handbook) due to a leave of absence or you are receiving disability benefits on the date coverage is supposed to begin, coverage begins on the day you return to Active Work if you return on the first day of the month, or on the first day of the month after your return to Active Work if you return on a day other than the first day of the month.
- **For Company Paid Life Insurance:** Coverage begins automatically on the date you become eligible, provided you are Actively at Work (as defined under the *Company Paid Life Insurance* section of this Handbook). If you are not Actively at Work due to a leave of absence or you are receiving disability benefits, coverage begins on the first day of the month following your return to Active Work status.

DEPENDENT COVERAGE

Coverage for your eligible dependents begins on the same date your coverage begins if they are enrolled when you first enroll. Otherwise, the date coverage begins is based on the event giving the right to coverage (for example, birth or marriage). For Transform medical, dental and vision coverage, you must enroll new dependents within 31 days of their eligibility date. If you don't, you won't be able to add your dependent until the next annual enrollment period or an applicable qualified change in status.

PAYING FOR COVERAGE

As part of the enrollment process, you must authorize Transform to deduct any required contributions from your paycheck. Contributions you make for yourself, your spouse and your eligible dependent children for the following benefits are made on a pre-tax basis:

- Medical Coverage;
- Dental Coverage;
- Vision Coverage;
- Health Care and Dependent Care FSAs ;
- Health Savings Account (HSA); and
- Commuter Benefits Program.

Contributing on a pre-tax basis allows Transform to withhold money from your paycheck before taxes are calculated. This means you do not pay federal income

tax, Social Security tax and, in most cases, state income tax on the amount of your income you contribute. Annual dollar limits established by the Internal Revenue Service apply to your pre-tax contributions under the Health Care and Dependent Care FSAs, HSA, and Commuter Benefits Program.

Associates on a paid or unpaid leave of absence, or Associates who are not on the payroll but are continuing their benefit plan coverage under COBRA, must make their contributions with after-tax dollars.

QUALIFIED CHANGES IN STATUS

You may only make changes to certain benefits during an annual enrollment period or when you experience certain events. If you are a part-time hourly Associate and you are eligible for the Medical Program based on hours of service, you may only make changes to certain benefits during an annual enrollment period or when you experience certain events. These events are defined by Federal law and are called qualified changes in status.

Changes to your benefit coverage made as a result of a qualified change in status must be made within 31 days of the event and must be consistent with that event. See the *Other Information* section of this Handbook for a list of the events that constitute a qualified change in status and details on each benefit plan.

SPECIAL ENROLLMENT OPPORTUNITIES FOR MEDICAL COVERAGE

Under a variety of circumstances, you may have special enrollment rights, including due to the addition of a dependent (due to marriage, birth or adoption), the loss of other coverage, and a loss of eligibility for coverage under Medicaid or a Children's Health Insurance Program (CHIP) plan, or a change in eligibility for premium assistance under Medicaid or a CHIP plan. Those rights are summarized in the *Other Information* section.

If you are a part-time hourly Associate, this section applies to Associates who were offered Medical Program coverage for the current plan year (or portion of a current plan year) but declined it.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- When you can make changes to your benefits.
- When coverage ends.
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Medical Program

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ABOUT THE MEDICAL PROGRAM OPTIONS

Health care is important to all of us. That's why the Medical Program component of the Plan (the "Medical Program") offers group health coverage options to eligible salaried and hourly Associates of Transform and its subsidiaries that participate in the Medical Program. All eligible Associates in the continental United States (including Alaska) have an opportunity to choose between the benefit options offered through Blue Cross Blue Shield of Illinois (BCBSIL). If you enroll in BCBSIL coverage, your prescription drug coverage will be provided through Express Scripts. Separately, Associates living in California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington or Washington D.C. are eligible to choose HMO coverage through Kaiser Permanente. Prescription drug coverage is also offered through Kaiser Permanente for those Associates enrolled in Kaiser Permanente coverage. Associates living in Puerto Rico are eligible for PPO coverage through Triple S or HMO coverage through an insurance carrier. Associates living in Hawaii, the Virgin Islands and Guam are eligible for HMO coverage through other insurance carriers.

All of these benefit options provide coverage of routine and preventive care, as well as catastrophic care. Some options are also designed to work in tandem with health savings accounts. As described above, the specific group health coverage options available to you depend on where you live. Eligibility is determined by your home zip code.

BLUE DISTINCTION CENTERS (BDC)

Under BCBSIL coverage, you have access to designated specialty care facilities that have met national measures for quality and cost-efficient care.

Specialty care services include:

- Bariatric surgery;
- Knee and hip replacement surgery;
- Transplant surgery; and
- Support services.

CONTRIBUTIONS

You are required to contribute toward the cost of your medical coverage. In general, the amount of your contributions will vary depending on the option you elect and the number of dependents you cover. Contribution rates are available online through **www.88sears.com** at the time you become eligible to enroll and during the annual enrollment period.

You should keep in mind the following regarding your medical contributions:

A $40 monthly Tobacco surcharge will be applied to your medical contributions if you and your covered dependents attest to being a tobacco user. Tobacco Cessation program is available through your medical plan. The Medical Program is committed to helping you achieve your best health. Tobacco Cessation Programs are available to you as a participant of the medical coverage you are enrolled in through Transformco, at no cost to you.

Rewards for participating in the Tobacco Free program are available to all Associates. Upon completion of a Tobacco Cessation Program during a coverage period, you are eligible to receive a full reimbursement of the surcharge applied to your medical contributions. You can contact the Transform Benefits Center at 1-888-887-3277, option 1 to request the Tobacco Cessation Claim Initiation Form. The Form will be reviewed by the Plan Administrator, upon approval a reimbursement of the surcharge will be processed through payroll within the next 1 -2 pay periods.

If you think you might be unable to meet the standards to receive the Tobacco Free Credit, you might qualify for an opportunity to earn the same reward by different means. Contact the Transform Benefits Center at 1-888-887-3277, option 1 and we will work with you (and, if you wish, with your doctor) to find an alternative with the same reward that is right for you in light of your health status.

A spousal surcharge is applied to your medical contributions if you cover a spouse who has access to medical coverage with another employer.

Generally, your contributions for your medical coverage, including any applicable surcharges or credits, are deducted from your paycheck on a pre-tax basis.

ELIGIBILITY AND MEDICAL PROGRAM BENEFITS

The *Introduction* section of the Handbook provides the eligibility rules for the Medical Program. For part-time hourly Associates, in general, your eligibility for participation in the Medical Program is determined by the Plan Administrator and is based on a review of actual hours worked during a specific period of time. Please review the *Introduction* section of this Handbook for eligibility information. The eligibility requirements within this Handbook take precedence over eligibility requirements included in any documents provided to you by BCBSIL, Kaiser Permanente or the other HMO providers or insurance carriers. While the Handbook sets the eligibility rules, it does not describe actual Medical Program benefits. Instead, for specific information about the benefits offered under each coverage option, you will need to consult the applicable booklet or certificate of coverage. The booklets or certificates of coverage control:

- Processes for filing claims.
- Appeal of denied claims.
- Collection of benefit overpayments.
- Coordination of benefits between the Medical Program and any other medical coverage you or a dependent may have.
- Rights to reimbursement when payments are available from other insurance sources or legal settlements.
- Other administrative processes.

You can contact BCBSIL, Kaiser Permanente or the other HMO providers or insurance carriers for more information about your medical coverage benefits. Call **1-888-887-3277, option 1** and choose the appropriate menu option to be connected to the relevant third-party administrator, HMO provider or insurance carrier. You can also access the website of your third-party administrator, HMO provider or insurance carrier at Your Benefits Resources through **www.88sears.com**. The booklets and certificates of coverage for the BCBSIL, Kaiser Permanente and other HMO and fully insured options are hereby incorporated by reference into this Handbook.

HOW THE BCBSIL COVERAGE OPTIONS WORK

BCBSIL offers three coverage options under the Medical Program: the Basic Option, the Enhanced Option and the Blue High Performance Network Option (BlueHPN). Health care, mental health care and prescription drug coverage are available with all options offered.

The Enhanced Option offered by BCBSIL is a Preferred Provider Organization (PPO) arrangement. PPOs are health plans that have a network of "preferred" providers from which you can choose. Under a PPO, you may receive care from providers who are either inside or outside of the network. If you choose a provider that is in-network, you will receive the highest level of benefits from your chosen coverage option. You'll also get the best discounted rates and spend less out of pocket when you choose in-network providers. In some cases, the PPO options do not cover services when obtained outside the network. Services provided by out-of-network providers are paid at out-of-network benefit levels even when in-network physicians refer participants to those providers.

The Basic Option offered by BCBSIL is a high deductible health plan (HDHP). HDHPs are very similar to PPOs, as described above. However, if you elect the HDHP, you will pay a higher annual deductible than in the PPO option. Similar to the PPO, you will have the choice of using in-network or out-of-network providers. You will pay 100% of your eligible health care expenses, including prescriptions, until you reach your annual deductible. Certain routine preventive care services are covered at 100% though, meaning no deductible will apply. Once you reach the out-of-pocket maximum, the HDHP pays the full cost of covered expenses.

If you choose the HDHP, you can also participate in the health savings account (HSA), as described below. An HSA enables you to save for covered medical expenses on a tax-preferred basis. Please note: The BCBS Basic Plan, Employee only medical tier will be the only 2025 plan offering that will be priced to the ACA Safe Harbor affordability calculation.

The BlueHPN Option offered by BCBSIL provides access to a select group of BlueHPN providers in more than 55 U.S. cities. You must use a BlueHPN provider to receive coverage under the BlueHPN Option. Services received from non-BlueHPN providers (i.e., out-of-network providers) are not covered, except in emergencies, accidents and urgent care. You do not need to select a primary care provider or get a referral to see a specialist. You may contact BCBSIL if you have questions what providers are BlueHPN providers.

When you enroll in a medical coverage option through BCBSIL, the benefits are self-insured, meaning Transform is responsible for the actual coverage and the medical care provided or arranged by BCBSIL.

All options offered by BCBSIL cover the same preventive care services at 100% when care is received in-network (or from a BlueHPN provider) for you and your covered dependents.

Puerto Rico Associates also have a PPO option available to them for medical coverage. The PPO option for Puerto Rico Associates is fully insured by Triple S. Because the Triple S PPO option is fully insured, Triple S, not Transform, is responsible for the actual coverage and the medical care it provides or arranges. Transform is not responsible for the quality of service provided or arranged by Triple S.

This Handbook does not describe the actual medical benefits offered by the BCBSIL options or, for Puerto Rico Associates, the Triple S PPO option. Your medical benefits are set forth in the booklet provided by BCBSIL for the coverage option in which you choose to participate, or the certificate of coverage provided by Triple S. Please refer to your booklet or certificate of coverage for further details pertaining to your medical coverage under the option that you elected.

HOW THE KAISER AND OTHER HMO COVERAGE OPTIONS WORK

A Health Maintenance Organization (HMO) is an independent health care organization that offers medical services to its members for a set monthly fee.

Kaiser Permanente offers two HMO coverage options under the Medical Program for Associates living in California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington or Washington D.C.: the Basic Option and the Enhanced Option. Health care, mental health care and prescription drug coverage are available with all options offered. The Basic Option is a HDHP.

The Kaiser Basic Plan, Employee Only medical tier will no longer be offered at the ACA Safe Harbor affordability calculation effective January 1, 2025.

Associates living in Puerto Rico, Hawaii, the Virgin Islands and Guam are eligible for HMO coverage through other insurance carriers.

A Health Maintenance Organization (HMO) is an independent health care organization that offers medical services to its members for a set monthly fee.

Transform may offer you the option to join an HMO; however the HMO, not Transform, is responsible for the actual coverage and the medical care it provides or arranges. Transform is not responsible for the quality of service provided or arranged by the HMO.

HOW TO USE AN HMO

- The HMO options under the Medical Program generally require, and other options may allow, the designation of a primary care provider. You have the right to designate any primary care provider who participates in the applicable option's network and who is available to accept you and your family as members. You can get information on how to select a primary care provider and how to obtain a list of participating primary care providers in the insurance certificate for the applicable option.
- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the HMO Options under the Medical Program 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 the applicable option's 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. You can get information on how to obtain a list of participating health care professionals who specialize in obstetrics or gynecology in the insurance certificate for the applicable option.
- Coverage varies from one HMO to another.
- Services you receive outside the HMO are not covered, except in emergencies. Your HMO can provide further details.
- You may have to pay a copayment or coinsurance to the HMO at the time you are treated. The HMO is generally responsible for the remaining cost of eligible expenses.
- You may call the Member Services department of the HMO if you have any questions. Member Services will give you information on providers within the HMO network.

This Handbook does not describe the actual medical benefits offered by the HMOs. Your medical benefits are set forth in the certificate of coverage provided by the HMO in which you choose to participate.

Please refer to your HMO materials for further details pertaining to your medical coverage under the HMO option that you elected. You can obtain HMO materials directly from your HMO.

HEALTH SAVINGS ACCOUNT

An HSA is an account that you can contribute money into on a pre-tax basis to save for qualified medical expenses. You are only eligible to contribute to an HSA if you are enrolled in the BCBSIL Basic Option or Kaiser Permanente Basic Option, which are HDHPs.

ELIGIBILITY

To be eligible to contribute to an HSA, you must satisfy all of the following conditions, as required by federal law:

- You must not be eligible to be claimed as a dependent on another person's tax return.
- You must not be enrolled in Medicare.
- You must be enrolled in a qualified "high deductible health plan" such as the BCBSIL Basic Option or Kaiser Permanente Basic Option.
- If you have additional health coverage under another plan, either as an Associate or a dependent, that other health coverage must also be a high deductible health plan or a plan providing specific, limited coverage (such as dental insurance, vision insurance, accident insurance, or long-term care coverage).
- If your spouse is enrolled in a health care flexible spending account through their employer, you cannot contribute to an HSA unless your spouse's health care flexible spending account excludes coverage for spouses and dependents who are covered by high deductible health plans.

You should consult with your tax advisor as to your eligibility to open an HSA.

CONTRIBUTIONS

The maximum HSA contribution is based on IRS guidelines for the coverage category you elect under the HDHP you choose. For instance, if you cover yourself only, you can contribute up to the amount of the "Associate only" deductible. If you also cover your spouse or children, you can contribute to the amount of the "family" deductible.

The 2025 IRS-prescribed annual HSA contributions limits for Associate only coverage is $4,300 per year and $8,550 per year for family coverage. If you are age 55 or older, you can make an additional "catch-up" contribution to your HSA, until you reach age 65. The catch-up contribution allowed by federal law is $1,000. You cannot contribute to your HSA if you are receiving Medicare payments.

***Important*:** You are responsible for ensuring that you are eligible to open and contribute to an HSA, and that you are not annually contributing more than permitted by law. These rules are not monitored by Transform, BCBSIL, Kaiser or the HSA administrator. If you are not eligible for an HSA or if you are eligible but contribute more than the legally permitted amount, you will be solely responsible for any taxes and penalties you incur as a result.

EMPLOYER MATCHING CONTRIBUTIONS

The Company currently provides a matching contribution of $250, $500, and $750 for individual or $1,000 and $1,500 for family coverage to eligible participants. The total amount that an associate can contribute has to be reduced by the Company contribution so that the associate and Company contributions combined do not exceed the IRS maximum limits.

The Company matching contribution requires associate participation of the minimum dollar amount with matching contributions deposited to active associate's accounts on a quarterly basis. The Company matching contribution amount is subject to change. Any changes will be communicated to you in your annual enrollment materials.

USING YOUR HSA CONTRIBUTIONS

You can use the funds in your account to pay for qualified medical expenses (as defined under Section 213(d) of the Internal Revenue Code (the "Code")) that are incurred by you, your spouse and dependents. Qualified medical expenses include deductibles and coinsurance under an HDHP as well as other expenses that the Medical Program does not cover, such as over-the-counter medication, dental expenses, and vision expenses. You can pay for medical expenses of your spouse and dependent children even if you do not cover them in an HDHP. Or, you can save the money in your account for future needs, such as retiree medical expenses; unlike a health care flexible spending account (see below), an HSA is not "use it or lose it" – unused amounts do rollover from year-to-year. Once you reach age 65, your HSA can be used to pay insurance premiums like Medicare Part A and B. However, HSA money cannot be used to purchase a Medigap policy.

You can also request a distribution of funds for other reasons; however, the amount distributed for other reasons will be subject to regular income taxes and, if you are not disabled or over age 65, a 20% penalty tax.

RULES ABOUT FLEXIBLE SPENDING ACCOUNTS

While you are contributing to an HSA, there are restrictions on coverage that you can have under a health care flexible spending account. If you enroll in both the Health Care Flexible Spending Account (FSA) under the Flexible Benefits Program (part-time hourly Associates are not eligible to participate in the FSA under the Flexible Benefits Plan) and the HSA, you will only be able to submit certain expenses to the Health Care FSA:

- Expenses that are not covered by your HDHP, such as dental or vision expenses; and
- Expenses you have incurred after you have satisfied your HDHP deductible.

If you participate in the Health Care FSA, claims will only be paid if they meet one of the above conditions. Also, the above conditions apply to carryover amounts that are used during a plan year in which you have a HSA.

If your spouse has a health care flexible spending account through their employer, you cannot contribute to an HSA unless your spouse's health care flexible spending account excludes coverage for spouses and dependents that are covered by high deductible health plans.

You cannot claim the same expense under both an HSA and a health care flexible spending account.

TAX SAVINGS

The potential tax savings associated with your HSA contributions include:

1. Tax deductions when you contribute to your account;
2. Tax-free earnings through investment; and
3. Tax-free withdrawals for qualified medical expenses.

HSA OWNERSHIP

Funds remain in the account from year-to-year. There are no "use it or lose it" rules for HSAs.

PORTABILITY

HSAs are completely portable. You are free at any time to move any or all of your HSA funds from one qualified HSA provider to another, including upon your termination of employment or authorized leave of absence without pay. Please note, though, you may only make direct payroll contributions to an HSA through UMB Bank. In addition, you can only make contributions to your HSA while you are covered by a HDHP. Upon an authorized leave of absence with pay, HSA pre-tax contributions continue as long as you are enrolled in the HSA through UMB Bank and a Transform-offered HDHP. If you are on an unpaid authorized leave of absence, HSA pre-tax contributions will not continue, and upon your return from such leave, you will be required to actively elect to restart HSA pre-tax contributions (provided you are enrolled in a Transform-offered HDHP upon your return).

SETTING UP YOUR HSA

HSAs offered under the Medical Program are only available through the BCBSIL Basic Option or the Kaiser Permanente Basic Option. MyChoice Accounts administers the HSAs through UMB Bank. You may elect to establish your HSA at any time during the plan year, provided you are enrolled in the BCBSIL Basic Option. Once you make an election to establish an HSA, you will receive information from MyChoice Accounts with instructions on how to activate your account at UMB, as well as a debit card to use when paying for qualified expenses. You cannot use your HSA account until you activate it.

You are also permitted to establish an HSA at a qualified HSA provider other than UMB Bank, but you will not be able to make direct payroll contributions to such HSA.

CHANGING YOUR HSA PRE-TAX CONTRIBUTION ELECTION

Once you have established an HSA, you may elect to stop making or change the amount of your pre-tax contributions to your HSA on a prospective basis for the remainder of the year, in accordance with the Plan Administrator's procedures for processing election changes and subject to the annual contribution limits described above.

IMPORTANT NOTE

The HSA is not an employer sponsored welfare benefit plan for purposes of the Associate Retirement Income Security Act of 1974 (ERISA), as amended.

EXPRESS SCRIPTS RX PROGRAM

MEMBER CHOICE NETWORK

The Member Choice Network focuses on generating Plan savings by asking participants to choose their anchor pharmacy chain, either CVS or Walgreens, for 30-day or 90-day supply retail prescriptions. However, once a participant chooses their anchor pharmacy chain, they are not required to use only CVS pharmacies or Walgreens pharmacies, they just can't use the anchor pharmacy they did not choose.

SMART 90 EXCLUSIVE

Participants will be required to fill 90-day maintenance medications at CVS or Walgreens anchor pharmacies that they selected.

OUT-OF-POCKET PROTECTION

This program adjusts copayment assistance from participants' accumulated deductible and out-of-pocket maximum to reflect only what participants themselves pay. When the program is in place, funds paid by copay assistance programs will no longer be applied to the accumulators.

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the Medical Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Medical Program, you may file an eligibility claim. If your eligibility for coverage or enrollment is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for coverage under the Medical Program, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - using a Claim Initiation Form to the Transformco Benefits Department at the following address or fax number:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 60 days after The Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

- The specific reason or reasons for the appeal decision;
- References to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant Program documents free of charge; and

- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

These procedures apply to claims for benefits relating to Medical Program coverage. As noted above, the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Medical Program. The appropriate claims administrator has the authority to decide the level of benefits that are available to an individual. The following chart provides information regarding the claims administrators for the Medical Program. You may also refer to the "Claims Administrators/Insurance Companies" chart in the *Other Information* section of this Handbook for contact information.

Program	Claims Administrator or Insurer
Medical Program	
▪ BCBSIL Basic (HDHP),Enhanced (PPO), and BlueHPN Options	Refer to your BCBSIL booklet or call the member services number on your identification card.
▪ Triple S PPO Option (Puerto Rico Associates)	Refer to your certificate of coverage or call the member services number on your identification card
▪ Kaiser HMO Basic (HDHP) and Enhanced Options (California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington or Washington D.C. Associates)	Refer to your Kaiser member handbook or certificate of coverage. You may also call the number on your identification card or visit **https://my.kp.org/transform/contact-member-services**.
▪ Other HMO Options (Puerto Rico, Hawaii, the Virgin Islands, Guam Associates)	Refer to your HMO member handbook or certificate of coverage.

Initial Claim Decision

When a claim is received for a medical benefit, the appropriate claims administrator must decide whether (or at what level) the medical benefit is covered under the Medical Program. When a medical benefit is provided or denied, you will receive a notice explaining how the benefit level was calculated or why benefits have been denied (the explanation of benefits (EOB), generally). How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim:

- An "urgent care claim" is any medical benefit claim where applying the non-urgent care time frames (1) could seriously jeopardize your health or ability to regain maximum function, or (2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or the treatment that is the subject of the claim. In accordance with the Affordable Care Act, the determination of whether a claim is an urgent care claim will be made by the attending provider, and the Plan will defer to such determination.
- A "pre-service claim" is a medical benefit claim that requires approval before you can receive coverage (in whole or in part) for the medical care.
- A "post-service claim" is any other medical benefit claim for example, a claim for reimbursement after the medical care is received.

Based on these definitions, the deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received;
- For a pre-service claim, 15 days after the claim is received (may be extended up to an additional 15 days);
- For a post-service claim, 30 days after the claim is received (may be extended up to an additional 15 days).

For a pre-service or post-service claim, these time periods may be extended for up to 15 days as long as the appropriate claims administrator determines that such an extension is necessary due to matters beyond the Plan's control and notifies you before the original deadline. This notice will describe why the extension is necessary. If you do not properly submit all the necessary information for your request for benefits, the claims administrator must notify you and tell you what information is missing. You have 45 days to provide the information needed to process your request for benefits. While the claims administrator is waiting on your additional information, that time period does not count toward the time frame in which the claims administrator must decide your claim.

For an urgent care claim, you may be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice.

If you fail to follow the procedures for filing an urgent care or pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice.

If you (or your authorized representative) submit an urgent care claim that is missing necessary information, you will

receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of the date the Program receives the requested information, or the end of the period you were given to provide the information.

Concurrent Care Claim

At times, the claims administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claims administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the appropriate claims administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claims administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive written notice of the claims administrator's decision based on whether that request is an urgent care or pre-service claim.

Proof of Claims

The claims administrator reserves the right to require verification of any claim for benefits. For example, the claims administrator may require submission of medical summaries, discharge reports, x-rays or other appropriate materials. Benefits may be reduced or not paid if verification cannot be made.

Appealing a Medical Claim Denial

If you disagree with a coverage decision or an adverse benefit determination, you (or your authorized representative) may request a full review by the appropriate claims administrator. You will have two "mandatory" appeals under the Plan's health care coverages. This means the appeal procedures described below apply at both levels.

Generally, a request for review of a denied claim should include:

- The Associate's name, address and telephone number;
- The Group Prefix and the Associate's identification number and the Group Number (if applicable) as it appears on the ID card;
- The name of the person denied benefits;
- The date the service was provided and the place of service (such as a physician's office, etc.);
- A description of the service and the charge for the service; and
- A statement of opinion as to why the denial was improper.

You must submit a request for review within 180 days after you receive the adverse benefit determination. Second level appeals must be made within 60 days of receipt of the first level appeal denial. A rescission of coverage is treated as an adverse benefit determination and may be appealed. (A rescission is a retroactive discontinuance of coverage that is not due to failure to pay required contributions.) Coverage under the Program will continue pending the outcome of an appeal related to rescission. In connection with your appeal, you or your authorized representative may:

- Submit written comments, documents, records and other information relating to the claim;
- Request copies of all relevant documents (free of charge);
- For medical coverage, receive (free of charge) any new or additional evidence considered, relied on or generated by the Program in connection with your claim, as soon as possible and sufficiently in advance of the date on which a denial notice is provided; and
- For medical coverage, receive (free of charge) any new or additional rationale on which your claim denial was based, as soon as possible and sufficiently in advance of the date on which a denial notice is provided.

You must send your appeal to the appropriate claims administrator identified above.

Your appeal will be reviewed by someone other than the person who made the first decision on your claim. The claims administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claims administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of the claims administrator's findings and decision in writing. Generally, this notice will be provided within a certain period after receiving the appeal, as described in the following chart. Remember, two levels of appeal are offered before the mandatory claims procedure is exhausted.

Claim Type	Medical
Urgent Claim	36 hours
Pre-Service Claim	15 days
Post-Service Claim	30 days

Claims Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- For medical coverage, information sufficient to identify your claim (including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- For medical coverage, the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim;
- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the adverse benefit determination is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures;
- For a final appeal with respect to medical coverage, a description of the external review process and how to initiate the review process;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim upon review; and
- For medical coverage, a disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

The notice will be provided in a culturally and linguistically appropriate manner, within the meaning of the Affordable Care Act.

Relevant Documents

The relevant documents that must be made available to you include documents, records and other information that:

- Were relied on in deciding your benefit claim;
- Were submitted, considered or generated in the course of deciding your benefit claim;
- Demonstrate that the decision complied with the Plan's administrative procedures or safeguards; or
- For a medical or disability claim, state the Plan's policy or guideline regarding the benefits for your diagnosis, whether or not it was relied upon.

External Review Process Under the Medical Program

You may request an external review for your medical coverage under the Plan. An "external review" is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, the experimental or investigational nature of a proposed service or treatment, involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act, or otherwise required by law. You will not incur any fees or costs as part of the external review process.

You may request a review by an external review organization if:

- You have received an adverse benefit determination from the claims administrator;
- Your claim was denied because the claims administrator determined that the coverage was not medically necessary or was experimental or investigational or a recission of coverage;
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the Plan's appeal process.

You must submit a request for an external review within 4 months after you receive a final decision from the claims administrator under the mandatory appeal process described earlier. The external review organization will then refer your case for review by a neutral, independent, board-certified physician with appropriate expertise in the area in question. In rendering a decision, the external reviewer may consider any appropriate creditable

information that you submit, and will follow the Plan's contractual documents and criteria governing the benefits.

The claims administrator will generally notify you of the external review organization's decision within 45 days after your request and all necessary information have been submitted. Expedited reviews are available if your physician certifies that a delay in service would jeopardize your health. Expedited reviews will be decided within three to five days of your request. The claims administrator will abide by the decision of the external review organization.

If you are not satisfied with the decision of the second level appeal or external review, you also have the right to bring a civil action under section 502(a) of ERISA, provided that you bring such action within 6 months of receiving an adverse benefit determination of your second level appeal in the U.S. District court of the Northern District of Illinois.

Legal Actions

Any decision on any matter within the claims administrator's or Plan Administrator's authority, upon final review of the appeal of a claim denial, will be made at the sole discretion of the claims administrator or Plan Administrator and will be final and binding on all parties (see the *Statement of ERISA Rights* provisions in the *Other Information* section). This includes determinations regarding Plan eligibility and plan terms made by the claims or Plan Administrator in good faith.

No legal action regarding an eligibility determination or claim for benefits can be initiated until you have exhausted the claims and appeals procedures for the applicable benefit program.

Once you have exhausted the claims and appeals procedures, if you wish to pursue legal action, you must bring such action within 6 months of receiving (or having been deemed to receive) an adverse determination of your final claim appeal in the U.S. District court of the Northern District of Illinois.

If you do not file legal action within the applicable timeframe set forth above, you will be barred from filing such action at a later date.

Note Regarding HMO and Other Fully-Insured Coverage: Your insurance company or HMO provider controls the process for filing claims, appeal of denied claims and coordination of benefits between the insurance company or HMO provider and any other medical coverage you have. If you need information about coverage or claims contact your insurance company or HMO provider. If you have a claim regarding covered services or payment of claims, refer to your certificate of coverage or contact the member service telephone number listed on the back of your ID card.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Medical Program must provide coverage to the child of an eligible Associate if required by the terms of a qualified medical child support order (QMCSO). If a QMCSO has been received by the Plan Administrator, benefits will be paid to the child specified in the QMCSO under the terms of the Medical Program, or such child's custodial parent or legal guardian, or to the provider if so directed by such child, custodial parent or legal guardian. A copy of the QMCSO procedures for the Medical Program can be obtained, without charge, from the Transform Benefits Center.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- When you can make changes to your benefits;
- Coverage continuation for certain benefits; and
- Contact information for benefit claims administrators and insurance carriers.

RESCISSIONS OF COVERAGE

The Medical Program may rescind (*i.e.*, cancel or discontinue on a retroactive basis) coverage if you or your dependents perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact. If the rescission relates to medical/prescription coverage, you and/or your dependents (as applicable) will receive at least 30 days advance notice before the coverage is rescinded.

Coverage may be retroactively terminated due to administrative delays in processing if necessary to implement an election or to correct an administrative error that resulted in enrollment in the wrong plan or level of coverage. Coverage also may be retroactively terminated due to a failure to timely pay required premiums or contributions toward the cost of coverage. Except where required by law, coverage may be terminated for these reasons without advance notice.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under the Women's Health and Cancer Rights Act of 1998 federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must cover the following medical and surgical procedures for breast reconstruction following a covered mastectomy:

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

This coverage is subject to the same annual deductible, coinsurance levels and preauthorization requirements that apply to other medical and surgical procedures.

INPATIENT ADMISSIONS IN CONNECTION WITH THE BIRTH OF A CHILD

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for

any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Medical Management must be notified for inpatient care (for either the mother or the child) that continues beyond the 48 or 96 hour limits.

RELEASE OF INFORMATION

Your election to participate in the Medical Program constitutes your agreement to release medical information for the purposes of administering the plan for compliance with state or federal law.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections **not** to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:

  Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

  Cover emergency services by out-of-network providers.

  Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.

  Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or, you can submit a complaint online at www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Continuity of Care Upon the Expiration of Provider Network Contract

To the extent required by the Consolidated Appropriations Act, each applicable Benefit Program (e.g., the Medical Program) will provide continued transitional care to a "continuing care patient" within the meaning of, and subject to the requirements of, the Consolidated Appropriations Act (e.g., via Section 718 of ERISA and/or Section 9818 of the Code, as applicable) and the rules of the Plan.

Mental Health Parity and Addiction Equity Act

The Plan, to the extent its Benefit Programs provide mental health or substance use disorder ("MH/SUD") benefits, may not, under federal law, impose less favorable benefit limitations on those MH/SUD benefits than on medical/surgical benefits, as required under the Mental Health Parity and Addiction Equity Act of 2008, as amended ("MHPAEA").

Compliance with all Other Applicable Federal Laws

The Plan is intended to be interpreted and administered in accordance with all other applicable federal laws and requirements, including, without limitation, the requirements under the Affordable Care Act, MHPAEA, and the Consolidated Appropriations Act.

IMPORTANT NOTE

The Medical Program is a welfare benefit plan under ERISA. This section of the Handbook, together with the applicable provisions of the *Introduction* and *Other Information* sections and the booklet or certificate of coverage provided by the third-party administrator or insurance company are intended to constitute an SPD in accordance with ERISA.

Dental Programs

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ABOUT THE DENTAL PROGRAM

The Dental Program component of the Plan (the "Dental Program") offers dental coverage designed to help you financially when you or your covered dependents need dental care.

The Dental Program includes two coverage options insured and administered by MetLife – a Basic Option and an Enhanced Option, which are available in all locations except in Guam. The Basic and Enhanced Options both utilize MetLife's PDP Plus (Preferred Dental Program) network of providers. A portion of most dental care is covered whether it is received in or outside the PDP Plus network.

Associates employed in Puerto Rico can choose between the Basic and Enhanced Options through MetLife, and a coverage option insured and administered by Triple S. Triple S can provide detailed information about the benefits provided by that option. Puerto Rico Associates will have new option that allows out of network benefits to be processed using the negotiated fees as the maximum allowable cost. Associates can contact Triple S through the Transform Benefits Center at **1-888-887-3277, option 1** for health benefits.

Associates employed in Guam can participate in a dental option insured and administered by NetCare. NetCare will provide eligible Associates in Guam with detailed information about the dental option available to them.

For more information on dental benefits, visit the Benefits section at **www.88sears.com**. You can also call **1-888-887-3277, option 1** for health benefits.

Note: Throughout this section of the Handbook, several terms are capitalized. These terms are defined under *Some Terms You Should Know*, at the end of this section.

CONTRIBUTIONS

You are required to pay contributions for your dental coverage. Contributions by active participants are made through payroll deductions on a pre-tax basis. The amount of your contributions will vary depending on the number of family members you cover and the coverage option you choose. Contribution rates are provided to you at the time you become eligible to enroll and during each annual enrollment period.

HOW THE PROGRAMS WORK

The "Introduction" section of the Handbook provides the eligibility rules for the Dental Program. Please refer to that section for an explanation of which Associates and dependents are eligible for Dental Program coverage. If a certificate of coverage provided by an insurance company contains eligibility rules inconsistent with this Handbook, the eligibility rules in this Handbook will govern.

Below is information regarding the Basic and Enhanced Options offered through MetLife. For information regarding the other dental coverage options (MetLife and Triple S in Puerto Rico and NetCare in Guam), refer to the certificates of coverage provided to you once you enroll.

	In-Network and Out-of-Network	
	Basic Option	**Enhanced Option**
Annual Deductible*		
Individual	$75	$50
Family	$200	$150
Annual Benefit Maximum	$1,500 per person	$2,000 per person
Orthodontia		
Coverage	Child only (under age 19)	Child only (under age 19)
Lifetime Maximum Benefit	$1,000 per child	$1,500 per child

*The Annual Deductible does not apply to cleaning of teeth (oral prophylaxis), oral exams, fluoride treatments, certain diagnostic tests, sealants, bitewing x-rays or full mouth x-rays.

For more detailed information about your Dental Program benefits, you can also contact your insurer. Call **1-888-887-3277** and choose the appropriate menu option to be connected to your insurance company. You can also access your insurance company's website through the Benefits section at **www.88sears.com**. The certificates of coverage for these offerings are hereby incorporated by reference.

IN-NETWORK VS. OUT-OF-NETWORK

The Dental Program benefit options provide more coverage if you use a provider that has contracted with the insurance carrier (an in-network provider).

The Basic and Enhanced Options insured through MetLife use a MetLife Preferred Dental Program (PDP Plus). Benefits payable when services are provided by an In-Network Dentist are based on the fee schedule approved by MetLife. When services are provided by an Out-of-Network Dentist, the benefits payable are limited to the Usual and Prevailing (Reasonable and Customary) Charge limits, as determined by MetLife.

LOCATING A DENTIST

To locate a Dentist, visit **www.metlife.com**. At the home page, click Find a Dentist, select the network type PDP / PDP Plus, then enter your ZIP code and click Find a Dentist. A list of Dentist will appear, search could be narrowed down by filtering the results.

Puerto Rico Associates who participate in the Triple S option can find out which Dentists are in-network by contacting Triple S.

Guam Associates can find out which Dentists participate in NetCare's option by contacting NetCare.

ALTERNATE BENEFIT

If MetLife determines that a less costly service could have been performed to treat a dental condition, benefits will be paid based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a covered service.

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, MetLife may base its benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, MetLife may base its benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, MetLife may base its benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, MetLife may base its benefit determination upon the partial denture which is the less costly service.

If benefits are paid based upon a less costly service in accordance with this subsection, the Dentist may charge you or your dependent for the difference in cost between the service that was performed and the less costly service. This is the case even if a network Dentist performs the service.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes, these separate steps of one service are considered to be part of the more comprehensive service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Dental Program will only pay benefits for the root canal therapy.

PREDETERMINATION OF BENEFITS

You should obtain a pre-treatment estimate of benefits from MetLife if your necessary dental treatment is expected to be more than $300. A predetermination of benefits is designed to avoid any misunderstandings between you, your Dentist, and the claims administrator regarding how much the plan will pay for a particular covered service. Confirm with your Dentist that he/she will submit a claim detailing the services to be performed and the amount to be charged by the Dentist. After receiving this information, MetLife will provide you with an estimate of the dental insurance benefits available for the service. The estimate is not a guarantee of the final amount MetLife will pay. Benefits paid may vary from the pre-treatment estimate based on such factors as: the actual services performed, and any service charge changes that occur in the time between when the pre-treatment estimate was made and the actual service was performed. Under the Alternate Benefit section above, the pre-treatment estimate may be based on the cost of a service other than the service that you choose. MetLife must receive proof on or after the date the dental service is completed in order for benefits to be considered for such service.

The pre-treatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pre-treatment estimate of benefits. As always, you or your dependent and the Dentist are responsible for choosing the services to be performed.

HOW BENEFITS ARE DETERMINED

Benefits are paid as shown in the Basic Option and Enhanced Option on the next pages, subject to the annual and lifetime maximums shown.

MetLife may ask for diagnostic and evaluative materials, such as X-rays, to help determine the amount of covered dental expenses. If they are not provided, MetLife will determine covered dental expenses on the basis of the information that is available. This may reduce the amount of benefits that would otherwise have been payable.

PROGRAM FEATURES

The following pages show program features for dental coverage options through MetLife. Contact the insurers for information on other dental option offered (through MetLife in Puerto Rico, NetCare in Guam or Triple S in Puerto Rico).

		In-Network and Out-of-Network[2]
Exams	Oral examination[1]	100%
	Prophylaxis, including scaling and polishing[1]	100%
	Fluoride (children under age 18)[1]	100%
	Sealants (children under age 19)[1]	100%
X-Rays	Bitewing x-rays[1]	100%
	Full mouth x-rays[1]	100%
	Periapical x-rays	70%
Endodontics	Pulpotomy	70%
	Root canal therapy, anterior or bicuspid tooth, with x-rays and cultures	70%
	Apicoectomy	70%
	Root canal therapy, molar teeth, with x-rays and cultures	70%
Minor Restorations	Amalgam (silver) fillings	70%
	Composite fillings (**molar teeth excluded**)	70%
Periodontics	Scaling and root planing[1]	70%
	Gingivectomy	70%
	Osseous surgery	70%
Oral Surgery	Incision and drainage of abscess	70%
	Uncomplicated extractions	70%
	Surgical removal of erupted tooth	50%
	Surgical removal of impacted tooth (soft tissue)	50%
	Surgical removal of impacted tooth (full or partial bony)	50%
Prosthodontics/ Major Restorations	Inlays/onlays[1]	50%
	Crowns[1]	50%
	Full and partial dentures[1]	50%
	Implants[1]	50%
	Implant repairs[1]	50%
	Implant supported prosthetics[1]	50%
	Denture repairs	70%
Anesthesia	General Anesthesia/IV sedation in connection with oral surgery (other than surgical extractions)	70%
	General Anesthesia/IV sedation in connection with surgical extractions	50%
Space Maintainers	Space maintainers are limited to children under age 19	100%
Orthodontia	Coverage	Child only (under age 19)
	Coinsurance	50%
	Orthodontia Deductible - Lifetime	$50
	Lifetime maximum	$1,000

[1] Frequency and/or age limitations apply to these services.

[2] Benefits under the out-of-network dental option are subject to Usual and Prevailing (Reasonable and Customary) Charge limits.

ENHANCED OPTION

		In-Network and Out-of-Network[2]
Exams	Oral examination[1]	100%
	Prophylaxis, including scaling and polishing[1]	100%
	Fluoride (children under age 18)[1]	100%
	Sealants (children under age 19)[1]	100%
X-Rays	Bitewing x-rays[1]	100%
	Full mouth x-rays[1]	100%
	Periapical x-rays	80%
Endodontics	Pulpotomy	80%
	Root canal therapy, anterior or bicuspid tooth, with x-rays and cultures	80%
	Apicoectomy	80%
	Root canal therapy, molar teeth, with x-rays and cultures	80%
Minor Restorations	Amalgam (silver) fillings	80%
	Composite fillings (**molar teeth included**)	80%
Periodontics	Scaling and root planing[1]	80%
	Gingivectomy[1]	80%
	Osseous surgery[1]	80%
Oral Surgery	Incision and drainage of abscess	80%
	Uncomplicated extractions	80%
	Surgical removal of erupted tooth	50%
	Surgical removal of impacted tooth (soft tissue)	50%
	Surgical removal of impacted tooth (full or partial bony)	50%
Prosthodontics/ Major Restorations	Inlays/onlays[1]	50%
	Crowns[1]	50%
	Full and partial dentures[1]	50%
	Implants[1]	50%
	Implant repairs[1]	50%
	Implant supported prosthetics[1]	50%
	Denture repairs	80%
Anesthesia	General anesthesia/IV sedation in connection with oral surgery (other than surgical extractions)	80%
	General anesthesia/IV sedation in connection with surgical extractions	50%
Space Maintainers	Space maintainers are limited to children under age 19	100%
Orthodontia	Coverage	Child only (under age 19)
	Coinsurance	50%

		In-Network and Out-of-Network[2]
	Lifetime maximum	$1,500

[1] Frequency and/or age limitations apply to these services.

[2] Benefits under the out-of-network dental option are subject to Usual and Prevailing (Reasonable and Customary) Charge limits.

GENERAL EXCLUSIONS, FREQUENCIES AND LIMITATIONS

The Basic and Enhanced Options do not pay benefits for:

- Services or supplies received by you or your dependent before the dental insurance starts for that person.
- A charge for a service not reasonably necessary or not customarily performed.
- A charge for a service furnished by a government plan.
- Adjustment of a denture made within 6 month after installation by the same dentist who installed it.
- A charge for replacement or modification of a denture, fixed or removable, or for adding teeth to either, or for a replacement or modification of a crown or gold restoration within the prior 84 months (for Basic and Enhanced Option) after that denture, fixed or removable, crown or gold restoration was installed.
- A charge for relinings and rebasings of existing removable dentures, if at least 6 months have passed since the installation of the existing removable denture, for more than once in any 36 month period.
- A charge for any of the following services:
  - An appliance, or modification of one, if an impression of it was made before the person became covered.
  - A crown, denture or gold restoration, if a tooth was prepared for it before the person became covered.
  - Root canal therapy, if the pulp chamber for it was opened before the person became covered.
- A charge in connection with a service furnished for cosmetic purposes, unless otherwise required by law. Facings on molar crowns or dentures will always be considered cosmetic.
- A charge in connection with:
  - Injury arising out of, or in the course of, any work for wage or profit;
  - Disease covered, with respect to such work, by any workers compensation law, occupational disease law or similar law;
  - Services for which the Employer of the person receiving such services is required to pay; or
  - Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- A charge in connection with:
  - Replacement of lost or stolen appliances; or
  - Appliances or restorations needed to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition; or
  - Treatment for problems of the jaw joint.
- A charge for oral exams and/or problem-focused exams more than twice per calendar year.
- A charge for cleanings of teeth (oral prophylaxis), including scaling and polishing, more than twice per calendar year.
- A charge for more than two screenings per calendar year.
- A charge for more than two patient assessments per calendar year. (Patient assessments are limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.)
- A charge for topical fluoride for a child under age 18 more than twice in a calendar year.
- A charge for Sealants for a child under age 19 more than once per tooth in 60 months. (Only Sealants applied to non-restored, non-decayed first and second permanent molars are covered.)
- A charge for more than two sets of Bitewing x-rays per year for a child under age 19, and for more than one set of Bitewing x-rays per year for everyone else (for Basic and Enhanced Option).
- A charge for Full Mouth or Panoramic x-rays more than once every 60-month period (for Basic and Enhanced Option).
- A charge for Periodontal maintenance following active periodontal therapy for more than four times less the number of teeth cleanings received during such year.
- A charge for more than one Periodontal surgical procedure per quadrant in 36 months (for Basic and Enhanced Option).
- A charge for Periodontal scaling and root planning more than once per quadrant in 24 months (for Basic and Enhanced Option).
- A charge for a full mouth debridement more than once per lifetime.
- A charge for tissue conditioning more than once in a 36 month period.

- A charge for preventive resin restorations, which are applied to non-restored first and second permanent molars, more than once per tooth every 60 months.
- A charge for occlusal adjustments more than once in a 12 month period.
- A charge for replacement of any Cast Restoration (except an implant supported Cast Restoration) with the same or a different type of Cast Restoration more than once for the same tooth surface within 84 consecutive months of a prior replacement (for Basic and Enhanced Option).
- A charge for a prefabricated crown replacement more than once for the same tooth surface within 84 consecutive months (for Basic and Enhanced Option).
- A charge for a core buildup more than once per tooth in a period of 84 months (for Basic and Enhanced Option).
- A charge for posts and cores more than once per tooth in a period of 84 months (for Basic and Enhanced Option).
- A charge for implant services (including sinus augmentation and bone replacement and graft for ridge preservation) more than once for the same tooth position in an 84 month period, when needed to replace congenitally missing teeth; or when needed to replace natural teeth that are lost while the person receiving such benefits was insured for dental insurance.
- A charge for repair of implants more than once in a 12 month period.
- A charge for implant supported Cast Restorations more than once for the same tooth position in an 84 month period (for Basic and Enhanced Option).
- A charge for implant supported fixed dentures more than once for the same tooth position in an 84 month period (for Basic and Enhanced Option).
- A charge for implant supported removable dentures more than once for the same tooth position in an 84 month period (for Basic and Enhanced Option).
- A charge for a service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance.
- A charge for a service to the extent that it is above the Usual and Prevailing Fee in the area for dental care of a comparable nature, as determined by MetLife.
- Those charges for or in connection with services or supplies that are Experimental or Investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational when MetLife determines that:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - If required by the FDA, approval has not been granted for marketing; or
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or the written protocol or protocols used by the treatment facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.
- To the extent payment is unlawful where the person resides when the expenses are incurred.
- For charges that the person is not legally required to pay.
- Charges that are covered in whole or in part by another plan. (Refer to the Coordination of Benefits in the *Other Information* section of this Handbook.)
- Instruction for plaque control, oral hygiene and diet.
- Dental services that do not meet common dental standards.
- Charges incurred due to an accident, including anesthesia, except for injuries to the teeth due to chewing or biting of food.
- Temporary or provisional restorations
- Temporary or provisional appliances
- Separate charges for infection control
- Protective athletic mouth guards
- Bite registrations, precision or semi-precision attachments
- Services and supplies received from a hospital
- Charges for missed dental appointments
- Completion of claim forms or record processing
- Nitrous oxide analgesia
- Drugs or their administration
- Fixed and removable appliances for correction of harmful habits
- Caries susceptibility tests
- Labial veneers
- Intra and extraoral photographic images
- Appliances or treatment for bruxism (grinding teeth) including but not limited to occlusal guards and night guards
- Repair or replacement of an orthodontic device

- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease
- Decoration or inscription of any tooth, devise appliance, crown or other dental work
- Services for which the submitted documentation indicates a poor prognosis
- Personal supplies or devices, including but not limited to: water piks, toothbrushes or dental floss
- Consultations
- Duplicate prosthetic devices or appliances
- Services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist and which are for scaling and polishing of teeth or fluoride treatments.

Note: Benefits under the Dental Program will be reduced so that the total payment a participant receives will not be more than 100% of the charge for the dental services, taking into account coverage under this program and any medical expense plan or prepaid treatment program. (Refer to the Coordination of Benefits in the *Other Information* section of this Handbook.)

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the Medical Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Dental Program, you may file an eligibility claim. If your eligibility for coverage or enrollment is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for coverage under the Dental Program, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - using a Claim Initiation Form to the Transformco Benefits Department at the following address or fax:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled “Your Action Needed” with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator’s decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan’s appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the email address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Plan Administrator receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

These procedures apply to claims for benefits relating to Medical/Dental Program coverage. As noted above, the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Medical/Dental Program. Your insurance company (MetLife, Triple S or NetCare) controls the process for filing claims for benefits, appeals of denied claims for benefits and coordination of benefits between the insurance company and any other dental coverage you have. If you need information about coverage or claims, contact your insurance company. If you have a claim regarding covered services or payment of claims, refer to your certificate of coverage or contact the member service telephone number listed on the back of your ID card, or contact MetLife at the number below for claims under the Basic and Enhanced Options.

For information on filing claims for benefits in Puerto Rico and Guam, refer to the certificate of insurance issued by Triple S or NetCare, as applicable.

For the Basic and Enhanced Options, you must file a claim with MetLife whether you use an In-Network Dentist or not. Many Dentists will file the claim on your behalf. Should you need to submit a claim, you can obtain a claim form by calling MetLife's Dental Customer Service Center at **1-888-942-0854**, or you may download a claim form from **www.metlife.com** /dental. Generic and electronically submitted forms from your provider will also be accepted.

Mail the original claim form and itemized bills to:

MetLife Dental Claims
P. O. Box 981282
El Paso, TX 79998-1282

You should file your claims as soon as possible after services are received.

Post-service claims will be reviewed and responded to within 30 days of receipt. If there is not enough information to make a decision within 30 days, you will be notified in writing of the additional information needed and will have 45 days to respond. MetLife will make a decision within 15 days of receipt of the requested information, or if no response is received, within 15 days after the deadline for a response.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If you feel your claim for benefits has been improperly denied, you have the right to appeal the decision. You must appeal claims under the Basic and Enhanced Options in writing to MetLife at the address indicated on the claim form after receiving MetLife's decision.

You or your authorized representative will have 180 days from the date of an adverse benefit determination under the Dental Program to submit an oral or written request to appeal the determination to MetLife

Internal Review

The customer resolution team reviews non-clinical denial appeals with assistance, if needed, from their supervisor. For cases involving denials of coverage based on medical necessity, the customer resolution team forwards the case to the appropriate clinical business unit for review. The specific steps in the decision-making process may include a review of the following:

- Applicable policy or contract language
- Claims and utilization management guidelines and policies
- Relevant medical, dental, and vision records

If additional information was submitted in connection with your appeal, a comprehensive review letter explaining the reason for the appeal determination will be sent no later than 30 days from receipt of the information. If no additional information was submitted, a comprehensive review letter explaining the reason for the denial will be sent no later than 30 days from receipt of the appeal.

Expedited appeal determinations are made within 72 hours.

If an appeal is denied, the written notice will include the information set forth under *Claims Decision Notices*.

You or your authorized representative have 180 days after receipt of a decision on your first level appeal to request a second-level appeal.

If you or the provider/representative acting on your behalf is not satisfied with the outcome of the first-level appeal decision, you may submit a written request for further appeal review. For clinical appeals the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or first-level appeal. The practitioner must hold a current unrestricted license to practice medicine and be board certified by a specialty board of Medical Specialties.

If your second-level appeal is denied, a comprehensive review letter explaining the reason for the denial will be sent no later than 30 days from receipt of the second-

level appeal. The written notice will include the information set forth under *Claims Decision Notices*.

Claim Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the adverse benefit determination is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures;
- For a final appeal with respect to medical coverage, a description of the external review process and how to initiate the review process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim upon review.

External Review

Following the internal review process described above, you may appeal the decision if the coverage denial is based on the claims administrator's determination that the requested service or treatment is not medically necessary or is experimental or investigational and the cost of the service or treatment at issue for which you are financially responsible exceeds $500. You or a physician on your behalf may request an external review within 60 days after the internal appeal process has been exhausted.

An external review organization refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. After all necessary information is submitted, the external reviewer decides within 30 days of the request. Expedited reviews are available when your physician certifies that a delay in service would jeopardize your health. Once the review is complete, the decision of the external reviewer is final and binding.

If you are not satisfied with the decision of the second level appeal or external review, you also have the right to bring a civil action under section 502(a) of ERISA, provided that you bring such action within 6 months of receiving an adverse benefit determination of your second level appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- When you can make changes to your benefits.
- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers.
- Coordination of Benefits provisions.

SOME TERMS YOU SHOULD KNOW

Coinsurance is the amount payable by the covered person to the Dentist for specific services, as described earlier in this section.

Deductible is the amount of covered dental expenses that each person must incur in a Plan Year before benefits are payable for those services in that year. A person's Deductible for a Plan Year will be met when those eligible charges equal to the Deductible amount have been incurred for the person's dental care in that year.

The Deductible amount is shown earlier in Plan Features section.

Dentist means:

- A person licensed to practice dentistry in the jurisdiction where such services are performed or
- Any other person whose services, according to applicable law, must be treated as Dentist's services. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

The term includes a physician who performs a covered service. The term does not include you, your spouse, or any member of your immediate family including your and/or your spouse's parents, children (natural, step or adopted), siblings, grandparents or grandchildren.

In-Network or Participating Dentist is a Dentist who participates in the MetLife PDP Plus network and has an

agreement with MetLife to accept payment based on the fee scheduled established by MetLife.

Out-of-Network or Non-Participating Dentist means a Dentist who does not participate in the MetLife PDP Plus network.

Usual and Prevailing (Reasonable and Customary) Charge is:

- a charge for a service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance, as determined by MetLife; or
- a charge for a service to the extent that it is above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it is above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are as determined by MetLife.

IMPORTANT NOTE

The Dental Program is a welfare benefit plan under ERISA. This section of ERISA, together with the applicable provisions of the *Introduction* and *Other Information* sections are intended to constitute an SPD for the Dental Program in accordance with ERISA.

Vision Programs

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ABOUT THE VISION PROGRAM

The Vision Program component of the Plan (the "Vision Program") offers vision coverage designed to help you financially when you or your covered dependents need vision care.

The Vision Program includes two coverage options underwritten by Fidelity Security Life Insurance Company and administered by EyeMed – a Basic Option and a Premier Option. The Basic and Premier Options both utilize EyeMed's network of providers that includes private practitioners and premier retailers. In the event there is a conflict of language between the SPD and the insurance documents, the language in the insurance documents will control.

Associates in Guam are also offered vision care through EyeMed. For more information on vision coverage options offered to Guam Associates, contact EyeMed.

Note: Throughout this section of the Handbook, some terms are capitalized. These terms are defined under *Some Terms You Should Know*, at the end of this section.

HOW THE PROGRAMS WORK

The "Introduction" section of the Handbook provides the eligibility rules for the Vision Program. Please refer to that section for an explanation of which Associates and dependents are eligible for Vision Program coverage. If a certificate of coverage provided by an insurance company contains eligibility rules inconsistent with this Handbook, the eligibility rules in this Handbook will govern. Below is information regarding the Basic and Premier Options offered through EyeMed.

CONTRIBUTIONS

You are required to pay contributions for your vision coverage. Contributions by active participants are made through payroll deductions on a pre-tax basis (except as noted below). The amount of your contributions will vary depending on the number of family members you cover and the coverage option you choose. Contribution rates are provided to you at the time you become eligible to enroll and during each annual enrollment period.

For more detailed information about your Vision Program benefits, (including your Certificate of Coverage) you can also contact your insurer. Call **1-888-887-3277** and choose the appropriate menu option to be connected to your insurance company. You can also access your insurance company's website through the Benefits section at **www.88sears.com**.

USING IN-NETWORK PROVIDERS

The Vision Program benefit options provide more coverage if you use a provider that has contracted with the insurance carrier (an In-Network provider).

The Basic and Premier Options insured through EyeMed use the EyeMed Select Network ("Network") of providers and private practitioners, as well as premier retailers.

When making an appointment with an In-Network provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization, or Plan number, located on the front of your ID card. Confirm the provider is an In-Network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Vision Program.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable and the cost of non-covered expenses (for example, vision perception training).

LOCATING AN IN-NETWORK PROVIDER

To locate a provider that is in the EyeMed Network, visit **www.eyemed.com** and choose "Find an Eye Doctor", then choose the "Select" network after entering your zip code.

EXAMPLES OF IN-NETWORK BENEFITS

Below are some examples of how benefits are applied if a member receives services at an In-Network provider.

EXAMPLE 1

	Basic Plan	Premier Plan
If you choose to receive:	**You pay:**	**You pay:**
A comprehensive vision care exam	$0	$0
A frame up to a value of $130	$24	$0
A pair of single vision lenses	$10	$10
Standard anti-reflective coating	$45	$45
Total cost to you	**$79**	**$55**

EXAMPLE 2

	Basic Plan	Premier Plan
If you choose to receive:	**You pay:**	**You pay:**
A comprehensive vision care exam	$0	$0
Standard contact lens fit/follow up	$0	$0
Contact lenses – 4 boxes of disposable lenses- $150 retail	$35	$0
Total cost to you	**$35**	**$0**

ADDITIONAL DISCOUNTS FROM IN-NETWORK PROVIDERS

Under the Vision Program, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined in the Plan Features section. In addition, EyeMed provides an In-Network discount on products and services once your In-Network benefits for the applicable benefit period have been used. The In-Network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

Note: These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain name brand vision materials in which the manufacturer imposes a no-discount practice or policy. Discounts on non-covered services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

USING OUT-OF-NETWORK PROVIDERS

If you receive services from an Out-of-Network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Plan Features section in the following pages. To receive your Out-of-Network reimbursement, complete and sign an Out-of-Network claim form, attach your itemized receipts and send to the following address:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

You can access the form at **www.eyemed.com**, or by calling the EyeMed Customer Care Center at **1-866-565-1538**.

PROGRAM FEATURES

The following tables show plan features for vision coverage options through EyeMed.

Basic Option

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	$0 co-pay	Up to $35 in total for all comprehensive exam services; including dilation and refraction.
Dilation as necessary		
Refraction		
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	$0 co-pay, Paid-in-full fit and two follow-up visits	Up to $40
Premium Fit and Follow-Up	$0 co-pay, 10% off retail price, then apply $40 allowance	Up to $40
Frames	$0 co-pay, plus 80% of balance over $120	Up to $55
Standard Plastic Lenses		
Single Vision	$10 co-pay	Up to $25
Bifocal	$10 co-pay	Up to $40
Trifocal	$10 co-pay	Up to $55
Standard Progressive	$75 co-pay	Up to $40
Premium Progressive Tier 1-3	$95-$120	Up to $40
Premium Progressive Tier 4	$75 co-pay plus 80% of charge less $120 allowance	Up to $40
Standard Lens Options		
UV coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard scratch resistance	$15	N/A
Standard polycarbonate – Adults	$40	N/A
Standard polycarbonate – Kids Under 19	$0 co-pay	Up to $5
Standard anti-reflective coating	$45	N/A
Premium ant-reflective Tier 1 &2	$57-$68	N/A
Polarized	80% of retail price	N/A

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Other add-ons and services	80% of retail price	N/A
Contact Lenses**		
Conventional	$0 co-pay, plus 85% of balance over $120	Up to $92
Disposable	$0 co-pay, plus 100% of balance over $120	Up to $92
Medically necessary	$0 (paid in full by Plan)	Up to $200
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price (Whichever is lesser)	N/A
Frequency (based on Calendar Year)		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

* You are responsible to pay the Out-of-Network provider in full at time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Premier Option

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	$0 co-pay	Up to $35 in total for all comprehensive exam services; including dilation and refraction.
Dilation as necessary		
Refraction		
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	$0 co-pay, Paid-in-full fit and two follow-up visits	Up to $40
Premium Fit and Follow-Up	$0 co-pay, 10% off retail price, then apply $40 allowance	Up to $40
Frames	$0 co-pay, plus 80% of balance over $160	Up to $55
Standard Plastic Lenses		
Single Vision	$10 co-pay	Up to $25
Bifocal	$10 co-pay	Up to $40
Trifocal	$10 co-pay	Up to $55
Standard Progressive	$75 co-pay	Up to $40
Premium Progressive Tier 1-3	$95-$120	Up to $40
Premium Progressive Tier 4	$75 co-pay plus 80% of charge less $120 allowance	
Standard Lens Options		

	Your In-Network Cost	Your Out-of-Network Reimbursement*
UV coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard scratch resistance	$15	N/A
Standard polycarbonate – Adults	$40	N/A
Standard polycarbonate – Kids Under 19	$0 co-pay	Up to $5
Standard anti-reflective coating	$45	N/A
Premium anti-reflective Tier 1 & 2	$57-$68	
Polarized	80% of retail price	N/A
Other add-ons and services	80% of retail price	N/A
Contact Lenses**		
Conventional	$0 co-pay, plus 85% of balance over $150	Up to $120
Disposable	$0 co-pay, plus 100% of balance over $150	Up to $120
Medically necessary	$0 (paid in full by Plan)	Up to $200
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price (Whichever is lesser)	N/A
Frequency (based on Calendar Year)		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months

* You are responsible to pay the Out-of-Network provider in full at time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

GENERAL EXCLUSIONS

Your Vision Program contains several limitations and exclusions. Please see your Certificate of Insurance for a complete list. Your Certificate of Insurance is available, upon request, through the Transform Benefits Center. Call **1-888-887-3277, option 1** for health benefits.

CLAIMS INFORMATION

HOW TO FILE A CLAIM

The following information will help you to better understand the claim review and appeal process with respect to the Medical Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Vision Program, you may file an eligibility claim. If your eligibility for coverage or enrollment is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for coverage under the Vision Program, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - using a Claim Initiation Form to the Transformco Benefits Department at the following address or fax number:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled “Your Action Needed” with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator’s decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan’s appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator’s denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

These procedures apply to claims for benefits relating to Vision Program coverage. As noted above, the Plan Administrator has the authority to decide whether an

individual is eligible to participate in the Vision Program. Your vision services provider (EyeMed), through First American Administrators, ("FAA"), a wholly-owned subsidiary of EyeMed, controls the process for filing claims, and appeal of denied claims. If you need information about coverage or claims, contact your vision services provider. If you have a claim regarding covered services or payment of claims, refer to your certificate of coverage or contact the member service telephone number listed on your ID card, or contact EyeMed at the number below for claims under the Basic and Premier Options.

Claims will be decided within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If more time is needed to decide the claim, you will be sent a written notice of the extension, which will not exceed 15 days. If additional information is needed, you will be sent a written notice explaining the information needed. You will have 45 days to provide the information.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If your claim is denied, in whole or in part, you will be informed of the denial in writing. You may appeal the denial. An appeal must be in writing and received within 180 days of your notice of the denial. If you do not receive an Explanation of Benefits ("EOB") within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period is expired. Your appeal will be decided within 60 days after receipt. Your written appeal should include the following:

- The applicable claim number or a copy of the denial information or EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist in the completion of review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513- 492-3259

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

Claim Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the adverse benefit determination is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim upon review.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- When you can make changes to your benefits.
- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers.
- Coordination of Benefits provisions.

SOME TERMS YOU SHOULD KNOW

In-Network Provider is a provider who participants in EyeMed's Select network.

Out-of-Network means a provider who does not participate in EyeMed's Select network.

IMPORTANT NOTE

The Vision Program is a welfare benefit plan under the ERISA. This section of ERISA, together with the applicable provisions of the *Introduction* and *Other Information* sections are intended to constitute an SPD for the Vision Program in accordance with ERISA.

Flexible Benefits Program

(Premium Conversion, Health Care FSA and Dependent Care FSA)

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HOW THE PROGRAM WORKS

IN GENERAL

Transform sponsors the Flexible Benefits Program component of the Plan (the "Flexible Benefits Program") which provides two ways for you to save money.

The first way is by paying your premiums for your group medical, dental and vision insurance on a pre-tax basis through payroll deduction. (Your pre-tax deductions for medical coverage include any applicable surcharges and credits as detailed in the Medical Program section of the Handbook.) This is known as "premium conversion." You must be enrolled in the Transform Medical, Dental or Vision Program to be eligible for premium conversion with respect to such coverage (meaning you cannot use this Program to pay insurance from other sources).

The second way is by paying eligible health care and dependent care expenses through flexible spending accounts (FSAs). FSAs allow you to pay eligible expenses with pre-tax dollars by electing to contribute a certain amount of your pay to one or both (if eligible) FSAs:

- The Health Care FSA and/or
- The Dependent Care FSA.

At the time you enroll in one or both (if eligible) of the FSAs, you select an amount to be withheld from your paycheck on a pre-tax basis for the calendar year. Part-time hourly Associates are not eligible to participate in the FSAs under the Flexible Benefits Program.

You can be reimbursed for eligible expenses with pre-tax dollars in a FSA by submitting a claim to your Health Care or Dependent Care FSA. You also have the option of using a debit card (provided soon after you enroll) to pay for eligible health care expenses with your Health Care FSA.

Both premium conversion and FSA deductions reduce your taxable income. Because the amount you pay in pre-tax premiums and your FSA deductions are not considered taxable, you save by paying less income tax. The pre-tax pay you contribute to the FSA is available to reimburse you for eligible expenses.

Pre-tax deductions are withheld from your paycheck. The amount of your deduction is recorded in your FSA, which is administered by MyChoice Accounts (Businessolver).

There are a few ways to spend your funds. The easiest method is to use the MyChoice Accounts debit card that was mailed to you a few weeks before your plan began. Activate it according to the directions on the mailer and use it to purchase eligible items or pay for eligible services. You may also pay for eligible items with your own money and submit a claim for reimbursement online or via the MyChoice Mobile App. Finally, you may pay a provider, such as a doctor or lab directly with your account online or via the mobile app, and MyChoice Accounts will submit the payment to that provider on your behalf.

HIGHLY COMPENSATED ASSOCIATES

Because of certain IRS restrictions, an Associate who is considered a "highly compensated Associate" may not be eligible to participate in the Dependent Care FSA. The term "highly compensated Associate" is defined by the IRS. You will be informed if you are not eligible to establish a Dependent Care FSA because you are a highly compensated Associate.

CONTRIBUTION LEVELS

The following are the minimum and maximum contribution levels, as defined in IRS regulations for 2025:

Health Care FSA	
Minimum contribution	$120 per year
Maximum contribution	$3,300 per year

Note regarding Health Care FSA contributions: If your spouse also is employed by Transformco and separately participates in the Health Care FSA, you both are eligible to separately elect to contribute up to the $3,300 per year maximum.

Dependent Care FSA	
Minimum contribution	$120 per year
Maximum contribution	$5,000 per year

Note regarding Dependent Care FSA contributions: If your spouse also contributes to a dependent care spending account through their employer, your combined contributions cannot exceed $5,000 per year. Individuals who are married and file separate tax returns are limited to $2,500 per year.

If your pay is not sufficient to cover your FSA contribution during a particular pay period, future paycheck deductions will increase to account for the missed deductions.

FORFEITURE OF CONTRIBUTIONS & HEALTH FSA CARRYOVER ACCOUNTS

IRS regulations generally require that any money remaining in your FSAs be forfeited if unused for expenses that occur during the applicable Plan Year. You may submit claims through the following March 31 (the "Run-out Period") for expenses incurred during the previous FSA Plan Year. The Plan Year is defined as a calendar year.

You can carry over amounts that are unused in your Health Care FSA as of the end of the Run-Out Period. These amounts will be held in a "Carryover Account," which will reflect the aggregate of unused amounts from the current and prior Plan Years. Under IRS rules, a Carryover Account cannot exceed $660. This means that

amounts that would result in your Carryover Account exceeding $660 will be forfeited.

For example, if you contributed $3,050 to your Health Care FSA for 2025, but only incurred $2,100 in eligible medical expenses (leaving $950 unused), then, at the conclusion of the 2025 Run-out Period (March 31, 2026), you would have $660 in a Carryover Account for eligible medical expenses during the remainder of 2026 or during future Plan Years. Due to the IRS rules limiting the Carryover Account to $660, in this example $290 of the unused amounts in the Health Care FSA at the end of the Run-Out Period will be forfeited (permanently lost) and cannot be placed in the Carryover Account.

Carryover Accounts can be used by Associates and by former Associates during a period of COBRA continuation coverage. Note that the Plan Administrator may limit carry overs to those that meet a minimum dollar threshold.

Forfeitures of Health Care FSA contributions will be used by Transform first to make up any deficits incurred with respect to medical claims, and second to pay administrative expenses of the Health Care FSA. Forfeitures of Dependent Care FSA contributions will be used to pay administrative expenses of the Dependent Care FSA. Any remaining forfeitures of FSA contributions may revert to Transformco.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

ELIGIBLE EXPENSES

Eligible health care expenses are those incurred by you, your spouse or an eligible dependent during the FSA Plan Year (which is the calendar year). The expenses must be for health care and must not be payable from another source. Your dependents are those who qualify in the current calendar year for tax-qualified dependent status, as defined by the Code. Generally, your dependents are your children (meaning your natural, adopted, foster and stepchildren) who have not yet turned 26, along with certain other relatives (such as a parent or grandparent, or a child 26 or older) if they receive over half of their support from you. Dependents also include other persons who receive over half of their support from you if they live with you.

Eligible expenses cannot be reimbursed by your FSA if:

- Payment has been or can be made under any other benefit program or other insurance; or
- Expenses were incurred before your participation in the FSA began or after your participation ended; or
- Expenses were incurred after the end of the Plan Year for which contributions were made (except in the case of amounts in a Carryover Account); or
- Expenses were incurred prior to a change in contribution level (due to a qualified change in status) and are submitted for reimbursement against the new contribution amount.

If you are covered by an HDHP and contribute to an HSA, there are restrictions on coverage that you can have under a Health Care FSA. If you establish a Health Care FSA under the Flexible Benefits Program and a HSA under the Medical Program, you will only be able to submit certain expenses to your Health Care FSA such as:

- Expenses that are not covered by the HDHP in which you participate, such as dental or vision expenses, and
- Expenses you have incurred after you have satisfied the HDHP deductible.

Again, if you are covered by a HDHP and contribute to a HSA, then if you enroll in a Health Care FSA, claims will only be paid if they meet one of the above conditions. You cannot claim the same expense under both an HSA and a Health Care FSA. Also, the above restrictions apply to amounts in a Carryover Account that are used during a Plan Year in which you fund an HSA.

The following items are examples of eligible expenses under the Health Care FSA.

- Alcoholism or drug dependency treatment
- Birth control pills, if prescribed by a physician
- Chiropractor services
- Christian Science practitioner services, provided they are medical services
- Contact lenses, cleaning solution and supplies
- Deductibles and coinsurance
- Dental/doctor fees
- Drugs and medicines for medical care, if prescribed by a doctor
- Eyeglasses and eye exams
- Hearing aids
- Hospitalization
- Physicals
- Smoking cessation aids, if prescribed by a doctor
- Vaccinations and immunizations
- Expenses incurred for over-the-counter drugs and medicines obtained without a prescription and menstrual care products.

There may be other expenses that qualify for reimbursement under the Code. You cannot claim these expenses on your federal income tax return if you are claiming reimbursement from your Health Care FSA.

Note: You cannot use contributions to the Health Care FSA to pay for any dependent day care expenses.

For more information or a complete list of eligible expenses, consult the Code or other tax publications.

INELIGIBLE EXPENSES

Only medically necessary expenses can be reimbursed. Under IRS rules, over-the-counter drug expenses, except for insulin, are ineligible expenses under the Health Care FSA.

The following items are examples of expenses that are ineligible under the Health Care FSA. There may be other expenses that do not qualify for reimbursement.

- Medical/dental contributions or premiums (payments for other health plan coverage)
- Vitamins
- Marriage or family counseling
- Dance lessons, swimming lessons, etc. (even if recommended by your doctor for general improvement of your health)
- The cost of weight-loss or smoking cessation programs for general health purposes, unless prescribed by a doctor as being medically necessary for the treatment of a specific disease or condition
- Maternity clothes, diaper services, etc.
- Uniforms
- Care in a nursing home, if the reason for being there is other than to get medical care (for instance, custodial care)
- Household help (even if recommended by your doctor because you are unable to do housework)
- Health club dues, YMCA dues, steam bath, etc.
- Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Automobile insurance premiums, including the part of the premiums providing medical insurance coverage for persons injured in or by your car.
- Premiums paid for life insurance policies or policies providing payment for loss of earnings or for accidental loss of life, limb, sight, etc.
- Trips or vacations taken for relief of a specific condition, a change in environment, improvement of morale or general health purposes, even if you make the trip on the advice of a doctor
- Transportation expenses to and from work, even if your condition requires a special means of transportation
- Cosmetic surgery, unless necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- Electrolysis

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Dependent care expenses may be reimbursed through your Dependent Care FSA if they are necessary for you or your spouse to work. If you are single, the expenses reimbursed cannot be greater than your earned income (wages, salary and bonus). If you are married, the expenses reimbursed cannot be greater than your earned income or your spouse's earned income, whichever is less.

Generally, if you are married, both you and your spouse must work to receive reimbursement from a Dependent Care FSA. However, you may be reimbursed for dependent care expenses if your spouse is not employed but is:

- A full-time student, or
- Mentally or physically incapable of self-care.

For each month that your spouse is a full-time student or is disabled, earned income for your spouse will be considered to be:

- $250 if you have one dependent, or
- $500 if you have two or more dependents.

QUALIFYING DEPENDENTS

You may claim dependent care expenses for qualifying dependents. The Dependent Care FSA has a special definition for qualifying dependents. This definition applies to the Dependent Care FSA only.

Qualifying dependents include:

- Children under age 13 whom you claim as dependents on your federal income tax (as defined under the *Introduction* section of this Handbook).
- Any qualifying relative (as defined in the Code) who is physically or mentally incapable of caring for themselves, who lives with you at your residence for more than half of the taxable year, and whom you either claim as a dependent or whom you could claim as a dependent but for the fact that (1) you were yourself claimed as a dependent on another person's income tax return, or (2) the family member receiving care was married and filed a joint tax return, or (3) the family member receiving care had gross income that equaled or exceeded the dependent exemption amount for the year.
- Your spouse who is mentally or physically disabled and incapable of self-care and who lives with you at your residence for more than half the year.

If you are divorced or separated, your child may qualify if you have custody of the child, even if you do not claim them as a dependent on your tax return. If you are unsure whether your child qualifies, consult your tax advisor.

DEPENDENT CARE TAX CREDIT

You may elect to take a dependent care tax credit on your taxes, or you may participate in the Dependent Care

FSA if you are eligible. You may not apply dependent day care expenses toward both. You should choose carefully between the tax credit and the Dependent Care FSA. Consult with your tax advisor to determine which option is better for you.

ELIGIBLE EXPENSES

Dependent care expenses must meet certain guidelines to qualify for reimbursement from the Dependent Care FSA.

- The services must be necessary to enable you and your spouse, if you are married, to work or attend school full-time.
- The service may be provided in your home or elsewhere, but not by anyone you declare as a dependent on your income tax return.
- If you use a day care facility that cares for more than six individuals who do not reside at the facility, it must comply with all applicable state and local laws and regulations and must receive a fee, payment or grant for its services.

Day care is an eligible expense until a child enters kindergarten and includes the cost of pre-school or private school attended before kindergarten. Before- and after-school care is eligible until a child reaches age 13.

Dependent care for an elderly or incapacitated dependent residing in your home is also an eligible expense.

The following are examples of eligible dependent/day care providers:

- A qualified day care center, nursery school, summer day camp or pre-school.
- A baby-sitter inside or outside the home.
- A housekeeper whose duties include day care.
- A person who cares for an elderly or incapacitated dependent.
- A relative who cares for your children or elderly or incapacitated dependent, as long as that relative is over 19 and is not claimed as a dependent on your federal income tax return.

Note: *Your dependent care provider must supply a tax identification number or their Social Security number for you to receive reimbursement.*

INELIGIBLE EXPENSES

The following are dependent care expenses that are not eligible expenses under the Dependent Care FSA:

- Expenses for your dependent attending school (except expenses before the child reaches kindergarten)
- Expenses for services rendered by an individual you claim as a dependent and for whom you are entitled to a personal exemption on your tax return
- Expenses for services rendered by a child of yours under age 19 (even if you do not claim that person as a dependent on your income tax return)
- Any expenses that are claimed as tax credits on your income tax return
- Any expenses that, in the absence of this plan, could not be claimed as credits on your federal income tax return, including educational expenses incurred for a child in kindergarten or higher grade level
- Any expenses incurred for a dependent attending an overnight camp
- Any expenses for day care or before- and after-school care not necessary for you and your spouse to work

CLAIMS INFORMATION

Reimbursement from your Health Care FSA is available only after the service for which you are seeking reimbursement has been performed and you have received reimbursement from all other sources. However, reimbursement from your Health FSA is available for advance payment of orthodontia services, so long as you have made the advance payment and have received reimbursement from all other sources. To be reimbursed for your health care or dependent day care expenses, you must file a claim or use the debit card associated with your Health Care FSA.

HEALTH CARE CLAIMS

Expenses eligible for reimbursement by another medical or dental plan must be submitted to that plan first. After a determination or payment has been made by that plan, the unreimbursed expense can be submitted for reimbursement to your FSA.

The full annual amount you elect to contribute to your FSA (less any previous reimbursements for the year) will be available for reimbursement of eligible health care expenses, regardless of the amount contributed to date. Contributions will continue to be taken to cover any claims already fully reimbursed from the Health Care FSA.

Note*: Special provisions apply if you terminate coverage. Please refer to the Other Information section for more detail.*

DEPENDENT CARE CLAIMS

A dependent care claim may be submitted up to one month in advance of the time service will be performed if the provider of service:

- Signs the claim form and
- Indicates that payment is not refundable.

The name, address, signature and taxpayer ID number or Social Security number of the provider are also required.

Only your current Dependent Care FSA balance is available to reimburse claims. If the dependent day care services exceed your account balance, a partial payment

will be made. The unreimbursed portion of the claim will be paid as you make additional contributions to your Dependent Care FSA.

Claim Submission

You may submit claims throughout the year as you incur expenses. If you submit a claim at the end of the year (or by the filing deadline) that exceeds your account balance for that year, the claim will be reimbursed only up to the amount remaining in your account.

Claim forms can be obtained online at MyChoice Accounts, through **www.88sears.com** or by contacting the Transform Benefits Center through **1-888-887-3277, option 1**. Follow the directions on the forms to submit your completed forms and supporting documentation.

Keep all original supporting documentation of your expenses, including receipts.

Filing Deadline

The Plan Year for the Flexible Benefits Program is January 1 to December 31. Claims under the FSAs may be submitted at any time after the expense is incurred but not later than March 31 of the next year.

Generally, any amount remaining in your account after March 31 will be forfeited. However, if an amount remains in your Health Care FSA as of March 31st, that amount will be placed in a Carryover Account (which cannot exceed $640). Please refer to the "Forfeiture of Contributions & Health FSA Carryovers" section for a discussion of Carryover Accounts.

Claims Review and Appeal Process

The following information will help you to better understand the claim review and appeal process with respect to the Flexible Benefits Program.

If You Have an Eligibility Claim

If you believe that you have improperly been denied the chance to participate in the Flexible Benefits Program, you may file an eligibility claim. If your eligibility for coverage or enrollment is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for coverage under the Health Care FSA, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Health Care FSA Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Flexible Benefits Program will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - using a Claim Initiation Form to the Transformco Benefits Department at the following address or fax number:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic claim form to complete and submit to the Transform Benefit Center.

The Transform Benefit Center will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transform Benefit Center receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a second adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transform Benefit Center at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transform Benefit Center receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A HEALTH CARE FSA CLAIM

If you feel your claim for health care benefits has been improperly denied, you have the right to appeal the decision.

Claims will be reviewed and responded to within 30 days of receipt. If more time is needed to decide the claim, you will be sent a written notice of the extension, which will not exceed 15 days. If additional information is needed, you will be sent a written notice explaining the information needed, and will have 45 days to respond. Your Spending Account will make a decision within 15 days of receipt of the requested information, or if no response is received, within 15 days after the deadline for a response.

HOW TO APPEAL A DENIED HEALTH CARE FSA CLAIM

If you are dissatisfied with the initial claims decision, you may file an appeal to request to have the administrator reconsider the claim denial. The person making the decision on a Health Care FSA appeal will be someone other than the person who made the initial denial decision, and will not be a subordinate of that person. Appeals may be filed by phone or in writing by contacting the following address:

MyChoice Accounts
MSC 345475
P.O.Box 105168
Atlanta, GA 30348-5168
Fax 855-883-8542
Email: claims@mychoiceaccounts.com

Your request must be received within 180 days of the date of the initial claim decision. If the appeal is not submitted within that timeframe, it will not be reviewed and the initial decision will stand. Your Spending Account will complete its review within 60 days of receipt of the appeal.

If your appeal is denied, the adverse benefit determination will include the specific reasons for determination and reference to the plan provisions on which the determination is based.

Claim Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim upon review.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under section 502(a) of ERISA if your appeal is denied, provided, however, that you bring such action within six months after you receive an adverse benefit determination of your final appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

IMPORTANT NOTE

The Health Care FSA is governed by Code Section 125 and ERISA, as amended. This section of the Handbook, together with the applicable provisions of the *Introduction* and *Other Information* sections are intended to constitute an SPD in accordance with ERISA.

The Dependent Care FSA is governed by Code Section 125 but is not governed by ERISA.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- When you can make changes to your benefits
- Coverage continuation for certain benefits

- Contact information for benefit claims administrators and insurance carriers

Short-Term Disability Program (Full-time Hourly Associates)

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SHORT-TERM DISABILITY PROGRAM (FULL-TIME HOURLY)

The Short-Term Disability Program component of the Plan (the "STD Program") is designed to help you cope with an off-the-job Illness or Injury, including pregnancy and childbirth, by providing benefits when you are unable to work. These benefits are provided at no cost to you. These benefits may be different for Associates residing in states that have certain disability laws as explained below. The STD Program is administered by New York Life. Part-time hourly Associates are not eligible to participate in the STD Program.

An Illness covered by the STD Program is a non-work-related Illness, including for this purpose pregnancy and childbirth, that disables you to the extent you are unable to perform your regular duties.

An Injury covered by the STD Program is an Injury sustained in a non-work-related accident which disables you to the extent you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Note: Throughout this section of the Handbook, several terms are capitalized. Those terms are defined at the back of this section, under *Some Terms You Should Know*.

HOW THE PROGRAM WORKS

ELIGIBILITY

Eligibility for the STD Program is based on your employment status and your length of employment. Full-time hourly Associates working for the Transform family of companies in a corporate Support Center are eligible for the STD Program.

These Associates are automatically covered by the STD Program after 90 days of continuous employment with the Company.

If your employment with the Company ends and you are rehired as a full-time Associate within 90 days of your date of termination, your STD coverage will be reinstated effective the date of your full-time rehire, provided you were covered by the STD Program at the time of your termination. If you are re-employed as a full-time hourly Associate within 90 days of your termination date, and you were not covered by the STD Program at the time of your termination (because you were still in a 90-day benefits eligibility period for STD benefits), you will not be covered by the STD Program until you complete 90 days of employment. In this case, your benefits eligibility period does not start over from your rehire date. Your previous service will be added to your current service to calculate the remaining days of your 90-day benefits eligibility period for STD benefits. If you are re-employed as a full-time hourly Associate more than 90 days after your termination, the full 90-days benefits eligibility period will apply.

Benefits under this program are payable beginning the fifteenth (15th) day you are off work if you are ill or injured and unable to work for more than fourteen (14) calendar days (the "Waiting Period"). You should call New York Life at 1-800-828-6352 regarding a leave of absence and to file your claim as soon as you think your absence for a disability may last longer than three (3) calendar days. Associate

Your manager or HR representative has responsibility for managing alternate pay during the Waiting Period. During the Waiting Period, you may use accrued vacation, personal days or Paid Sick Time (where applicable) to receive pay.

New York Life will provide case management services during your absence and will advise you of the time period for which you are eligible for STD benefits based upon your medical condition and the objective medical documentation that New York Life receives from your Physician(s) that supports your Disability.

If you do not contact New York Life, STD benefits may not be paid. If you call and request a return phone call, a case manager from New York Life will confidentially discuss your Illness or Injury with you and advise you regarding what is needed to process your claim.

During the Waiting Period, your manager or HR Representative may request that you provide a written statement from your Physician to support the need for your absence.

You are responsible for making sure your Physician submits medical documentation to CLMT and New York Life that supports your inability to work. They will obtain your authorization and/or your Physician may have you sign a form allowing him/her to release your medical records, so be sure to ask your Physician about this when you see him/her.

A CLMT consultant and/or New York Life case manager may also work with your manager or HR Representative to look at ways you can return to work – perhaps with modified job duties. If it's not possible for you to return to work after your STD benefits cease, your New York Life case manager can help you transition to the Long-Term Disability Program component of the Plan (the "LTD Program") if you participate in the LTD Program, or to community services that can help you with your Illness or Injury.

BENEFIT AMOUNT AND DURATION

Once eligible, while you are Disabled for purposes of the STD Program, you may receive a percentage of your pay. The Maximum Benefit during any 52-week period, required service and the Waiting Period required prior to receiving these benefits are provided in the following table:

Continuous Service Eligibility Period	Waiting Period	Maximum Benefit During Any 52-Week Period
90 days	14 calendar days	50% for 20 weeks

- The Waiting Period consists of fourteen (14) calendar days, including holidays and weekends.
- The Waiting Period is unpaid, however, you may use accrued but unused vacation, personal days or paid sick time (where applicable) during the Waiting Period.
- At your request, STD benefits may be supplemented with accrued and unused vacation hours, personal days or paid sick time hours (as applicable) to bring your pay up to 100% of pay.
- The Waiting Period requires you to be off work for fourteen (14) calendar days. However, if you return to work for up to one full work day during the Waiting Period and go out again, and your absence is due to the same cause, you will not have to begin a new Waiting Period, but your waiting period will be extended by one (1) day. However, if you return for less than one (1) day, that will still count as a full day out in your waiting period.
- You must be out for fourteen (14) continuous calendar days prior to benefits being paid on an approved claim by New York Life. Paid benefits begin on the fifteenth (15th) day. Your waiting period will still be continuous if your return to work was for no more than one day.

Once 20 weeks of STD benefits are exhausted within any 52-week period, no additional STD benefits are payable for the six (6)-month period following the exhaustion of the payment of STD benefits. You must return to full-time work for six (6) or more consecutive months before you are again eligible to receive STD benefits for a covered Illness or Injury.

STD benefits are only payable if you are taking time off pursuant to an applicable Transform leave of absence approved by New York Life.

STATE LAWS

In states that have mandatory disability coverage laws, any applicable payroll deductions are made and benefits are paid in accordance with the applicable state law. In those states, benefits are different than described in this section. States with mandatory disability programs at the time the Handbook was issued include California, Hawaii, New Jersey, New York, Rhode Island and the Commonwealth of Puerto Rico. If you work in one of these locations, New York Life can provide you with information regarding the specific state disability benefits. Associates who work in the Commonwealth of Puerto Rico are paid SINOT pay by the Commonwealth and the STD "topped up" benefit through payroll. Associates who work in Hawaii and New York are paid statutory disability benefits and STD through payroll. All others must apply to the state or commonwealth for any statutory benefits.

The following information should help you determine if your state has a plan or a program for Disability payments. If you work in one of these locations, New York Life will provide you with information regarding the specific state disability benefits. Please note, however, that statutory disability amounts and agency information are subject to change. The Elimination Period and benefits payable in these states for statutory disability benefits are based on state law.

Associates who work in California must file for statutory disability benefits directly with the state and file for "topped up" STD benefits with New York Life as follows:

California

- You must file for statutory disability benefits directly with the state:
- State of California EDD State Disability Insurance

  English: **1-800-480-3287**

  Spanish: **1-866-658-8846**

  Website: **http://www.edd.ca.gov/Disability/**
- You must file for "topped up" STD benefits with the Disability Claims Administrator: New York Life 1-800-828-6352

Associates who work in Puerto Rico must file for statutory disability benefits directly with the Commonwealth and file for "topped up" STD benefits with New York Life as follows:

Puerto Rico

- Phone 1-787-754-5353
- Website: https://www.trabajo.pr.gov

Associates who work in Rhode Island must file for statutory disability benefits directly with the state, as follows:

Rhode Island

- Disability Determination Services

  1-401-462-8420

  Website: **http://www.dlt.ri.gov/**

Associates who work in New Jersey must file for statutory disability benefits only with the Disability Claims Administrator as follows:

New Jersey

- Disability Claims Administrator: New York Life

  1-800-828-6352

EXCLUSIONS AND LIMITATIONS

Except if otherwise required by state law, STD benefits are not paid for:

- Time off for doctor's or dentist's appointments if you are not Disabled.
- Time off for non-medically necessary cosmetic procedures.
- Conditions involving your remaining at home because of appearance or neglect of bodily hygiene.
- Illness/Injury resulting from the use of alcohol or drugs. (However, if you are receiving medical care and treatment for alcoholism or drug addiction, the

absence is eligible for STD benefits while you are Disabled and unable to work.)

- Self-inflicted injuries or those that result from participation in riots, fights or other criminal acts.
- Emotional problems, nervousness or mental conditions, unless you are under the care of a Physician or supervision of a psychiatrist, or you are confined to a hospital or institution for treatment of such conditions.
- Work-related Injuries and Illnesses incurred during your assigned work with Transform.
- Situations where you or your Physician(s) refuse to cooperate with Transform or the New York Life case manager.
- Illness/Injury occurring while on leave of absence or while receiving LTD benefits from a Transform-sponsored LTD program.

STD benefit payments are not necessarily payable for absences due to operations and/or hospital confinements. If the condition for which the operation is performed or the hospital confinement that is required is not a covered Illness or Injury, no disability benefits will be paid for the absence.

Illness and Injuries cease being fully covered if alternate assignments or reduced hours schedules are available that you are able to perform. Should you refuse such assignments, STD benefits will cease.

Dental work should be performed on your own time. Should extensive dental work disable you to the extent that you are unable to perform your job, STD benefits may be paid if your Physician submits documentation to New York Life that supports your inability to work.

Disability benefits will not be paid if appearance is the only disabling factor.

STD benefits are paid entirely by Transform (or the participating affiliate) and can be withheld or terminated by Transform at any time. It is not the intent of Transform to indefinitely subsidize Associates' pay when they are repeatedly absent due to Illness or Injury.

You may not work elsewhere while receiving STD benefits without the advance approval of your manager.

HOW STD BENEFITS ARE PAID

STD benefits under this program are paid through Payroll according to your normal payroll schedule.

Eligible Associates who become ill or injured while on vacation are paid STD benefits instead of vacation pay (vacation days are deferred) if they:

- Have a covered Illness or Injury,
- Are under the care of a Physician,
- Present a statement from the Physician stating the diagnosis and the date they were first treated, and
- Satisfy the Waiting Period, if applicable.

STD benefits, or the tracking of the Waiting Period, will begin the first full day you are absent from scheduled work due to a Disability that is supported by medical documentation from your Physician.

The benefit duration is measured using a seven (7)-day calendar week, not a work week schedule. The STD benefit will not be converted to hours to adjust for a partial day worked or intermittent absences.

For example, assume that New York Life has determined that Pat's disabling medical condition is payable for four (4) weeks beginning on March 1. Pat's STD benefit will begin on March 1 and end on March 29 (four (4) calendar weeks). If during week four (4), Pat is released by the Physician to return to work for three (3) days or 24 hours, week four (4) remains a week of disability, not 24 hours worked. Pat's disability remains compensable through March 29.

WHEN DISABILITY BENEFITS END

Benefits under the STD Program will end upon the earliest of the following to occur:

- You are able to return to work full-time with or without medical restrictions;
- You have received the Maximum Benefit;
- Your employment terminates;
- You retire from Transform;
- You die;
- You fail to provide proof of disability; or
- You no longer meet the definition of Disabled.

WAIVER OF WAITING PERIOD

The Waiting Period is waived for a subsequent absence for the same Illness or Injury within four weeks from the date of return from the original absence if the Waiting Period was satisfied during the initial absence.

Subsequent absences due to chronic conditions, such as migraine headaches or asthma, are not considered absences for the same Illness or Injury. For example, each migraine headache is a new Illness, not a continuation of the previous Illness.

ALTERNATE ASSIGNMENTS / REDUCED HOURS SCHEDULES

Illnesses and Injuries cease being fully covered under the STD Program if alternate assignments or reduced hours schedules are available that you are able to perform. Should you refuse such assignments, STD benefits will cease. Associates who can return to work on reduced hours schedules are paid regular pay for hours worked and are paid STD benefits for the balance of their normal weekly work schedule.

ACCIDENTS AT ANOTHER COMPANY

If you are absent from work due to Illness or Injury resulting from employment with another company, you may be eligible, based on state law, to receive Workers Compensation benefits through the other company for time lost from Transform. In these cases, STD benefits

are adjusted or eliminated, as applicable. If you do not receive Workers Compensation benefits in such a case, you will be compensated according to the STD Program.

YOUR RIGHTS AND RESPONSIBILITIES

Unless prohibited by law, it is Transform policy to run time off under Transform's STD Program concurrently with time off under the federal Family and Medical Leave Act ("FMLA"), similar state laws, and /or the applicable Transform Leave of Absence policies. Many of the rights and responsibilities that apply under the FMLA, similar state laws and Transform's Family and Medical Leave ("FML"), Associate and Family Leave ("AFL"), and Extended Care Leave ("ECL") policies are independent of and/or in addition to the rights and responsibilities that apply under Transform's STD Program. Additional information about the FMLA may be found in A Notice to Associates of Rights under FMLA (WHD Publication 1420) at http://www.dol.gov/whd/regs/compliance/posters/fmla.htm . Information regarding Transform's FML, ECL and AFL policies can be found on PeoleDock > Compliance > Centralized Leave Management > Forms and Policies, or contact the CLMT at LEAVE90 LEAVE90@transformco.com for more information, or contact your manager, or HR representative.

Key responsibilities under the STD Program include, but are not limited to:

- You must give 30 days' advance notice of your need for the absence if your need is foreseeable. If it is not foreseeable, you must give Transform notice as soon as possible by calling the CLMT. Associate
- You must provide medical certification when asked.
- You must file a claim with New York Life and you also must provide the requested medical documentation to them.
- You must submit periodic updates as requested by the CLMT, New York Life, or your HR Representative, as applicable.
- When you are ready to return to work, you must provide a note from your Physician releasing you to return to work, with or without restrictions. If you fail to provide the required release to return to work, you will not be permitted to return to work, and your employment may be terminated.

Similar responsibilities may apply under the FMLA and FML, AFL, and ECL policies. Job restoration rights of Associates returning from time off under Transform's STD Program will be governed by applicable leave laws, the applicable leave of absence policy and, as applicable, the Americans with Disabilities Act and similar state laws. For Associates with qualifying disabilities, Transform will explore reasonable accommodations. Reasonable accommodations include, but are not limited to, reasonable additional leave, modified duty, modified schedules, part-time work, assistive devices and reassignment.

DIRECT BILLING FOR BENEFIT PAYMENTS

If your STD payments are insufficient to cover your benefit deductions, you may continue your other benefits (for example, medical, dental and vision insurance) by making payments on a post-tax basis. You will receive direct billing information from the Transform Benefits Center and are responsible for making timely payments for your benefits to prevent a lapse in coverage.

HOW TO FILE A CLAIM FOR BENEFITS

If you believe that you are eligible for STD benefits, you may file a claim for benefits with the claims administrator, New York Life. Contact New York Life at 1-800-828-6352.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If the claims administrator denies your STD claim and you wish to have the decision reviewed, you must submit a written request to the claims administrator for a review of the decision within 180 days of the receipt of the decision. This request should include why you disagree with the claims administrator's decision and any additional medical information that is available.

The appeal should be mailed to the claims administrator at the following address:

New York Life Group Benefit Solutions
P.O. Box 709015
Dallas, TX 75370-9015
Fax: 800-642-8553

The claims administrator will respond within 45 days of the receipt of the appeal. Under special circumstances, an additional 45 days may be required to review the claim. The claims administrator will notify the claimant if an additional 45-day extension is needed.

Notwithstanding the foregoing, appeals regarding the withholding of STD benefits due to failure in qualifying for a leave of absence (as determined by Transform) should be directed to the Transform Benefits Center.

IMPORTANT NOTE

The STD Program is a payroll practice that is exempt from welfare benefit plan status under ERISA. The fact that a summary of this program is included in this Handbook should not be construed as making it an ERISA plan.

FOR MORE INFORMATION

The following additional details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers
- How to appeal a denied claim.

SOME TERMS YOU SHOULD KNOW

Date of Disability is the date that a new disability begins.

Disabled means you are not able to perform your regular job duties as a result of an Illness or Injury defined below.

Illness means a non-work related illness, including for this purpose pregnancy and childbirth, which disables you to the extent that you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Injury means a non-work related injury sustained in an accident, incurred away from work that disables you to the extent you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Maximum Benefit is described above in the *Benefit Amount and Duration* section.

Physician means a person who is licensed or otherwise legally authorized to administer medical care or treatment so long as the person is acting within the scope of his/her license or authorization. Physician also means an accredited Christian Science practitioner listed in the current issue of the Christian Science Journal.

Waiting Period is the first fourteen (14) calendar days of an Illness or Injury, including holidays and weekends. STD benefits are not paid during the Waiting Period, and as otherwise described above in the *How the Program Works* and *Benefit Amount and Duration* sections.

Short-Term Disability Program (All Salaried Associates)

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SHORT-TERM DISABILITY PROGRAM

The Short-Term Disability Program component of the Plan ("STD Program") is designed to help you cope with an off-the-job Illness or Injury, including pregnancy and childbirth, by providing benefits when you are unable to work. These benefits are provided at no cost to you. These benefits may be different for Associates residing in states that have certain disability laws as explained below. The STD Program is administered by New York Life.

An Illness covered by the STD Program is a non-work related Illness, including for this purpose pregnancy and childbirth, that disables you to the extent you are unable to perform your regular duties.

An Injury covered by the STD Program is an Injury sustained in a non-work related accident, that disables you to the extent you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Note: Throughout this section of the Handbook, several terms are capitalized. Those terms are defined at the back of this section, under *Some Terms You Should Know*.

HOW THE PROGRAM WORKS

ELIGIBILITY

Salaried Associates are eligible for STD benefits under this STD Program.

Benefits under this program are payable beginning the fifteenth (15th) day you are off work if you are ill or injured and unable to work for more than fourteen (14) calendar days (the "Waiting Period"). You should call New York Life at 1-800-828-6352 regarding a leave of absence and to file your claim as soon as you think your absence for a disability may last longer than three (3) calendar days. Associate

Your manager or HR Representative has responsibility for managing alternate pay during the Waiting Period. During the Waiting Period, you may use accrued vacation, personal days or Paid Sick Time (where applicable) to receive pay.

New York Life will provide case management services during your absence and will advise you of the time period for which you are eligible for STD benefits based upon your medical condition and the objective medical documentation that New York Life receives from your Physician(s) that supports your Disability.

If you don't contact New York Life, STD benefits may not be paid. If you call and request a return phone call, a New York Life case manager will confidentially discuss your Illness or Injury with you and advise you regarding what is needed to process your claim.

During the Waiting Period, your manager or HR Representative may request that you provide a written statement from your Physician to support the need for your absence.

You are responsible for making sure your Physician submits medical documentation to the CLMT and New York Life that supports your inability to work. They will obtain your authorization and/or your Physician may have you sign a form allowing him/her to release your medical records, so be sure to ask your Physician about this when you see him/her.

A CLMT consultant and/or a New York Life case manager may also work with your manager or HR Representative to look at ways you can return to work - perhaps with modified job duties. If it's not possible for you to return to work after your STD benefits cease, your New York Life case manager can help you transition to the Long-Term Disability Program component of the Plan ("LTD Program") if you participate in the LTD Program or to community services that can help you with your Illness or Injury.

BENEFIT AMOUNT AND DURATION

As a salaried Associate, while you are Disabled for purposes of the STD Program, you may receive a percentage of your pay. The Maximum Benefit during any 52-week period and the Waiting Period required prior to receiving these benefits are provided in the following table:

Waiting Period	Maximum Benefit During Any 52-Week Period
14 calendar days	▪ 70% for the first 13 weeks ▪ 50% for the next seven (7) weeks.

- The Waiting Period consists of fourteen (14) calendar days, including holidays and weekends.
- The Waiting Period is unpaid, however, you may use accrued but unused vacation, personal days or paid sick time (where applicable) during the Waiting Period.
- At your request, STD benefits may be supplemented with accrued and unused vacation hours, personal or paid sick time hours (as applicable) to bring your pay up to 100% of pay.
- If you leave work early due to a covered Illness you are paid for that day.
- The Waiting Period requires you to be off work for fourteen (14) calendar days. However, if you return to work for up to one (1) full work day during the Waiting Period and go out again, and your absence is due to the same cause, you will not have to begin a new Waiting Period, but your waiting period will extended by one day. However if you return for less than one (1) day, that will still count as a full day out in your waiting period.
- You must be out for fourteen (14) continuous calendar days prior to benefits being paid on an approved claim by New York Life. Paid benefits begin on the fifteenth (15th) day. Your waiting period will still be continuous if your return to work was for no more than one day.

Once 20 weeks of STD benefits are exhausted within any 52-week period, no additional STD benefits are payable

for the six (6)-month period following the termination of STD payments. You must return to a full work schedule for six (6) or more consecutive months before you are again eligible to receive STD benefits for a covered Illness or Injury.

STD benefits are only payable if you are taking time off pursuant to an applicable Transform leave of absence approved by New York Life.

STATE LAWS

In states that have mandatory disability coverage laws, any applicable payroll deductions are made and benefits are paid in accordance with the applicable state law. In those states, statutory disability benefits are different than described in this section. States with mandatory disability programs at the time the Handbook was issued include California, Hawaii, New Jersey, New York, Rhode Island and the Commonwealth of Puerto Rico. If you work in one of these locations, New York Life can provide you with information regarding the specific state disability benefits.

- Eligible Associates:
  - Who work in New York and Hawaii must call in a claim directly to New York Life and will be paid state statutory benefits and STD benefits through payroll;
  - Who work in California, New Jersey, Rhode Island and Puerto Rico must apply to the applicable state or commonwealth for any statutory benefits and also must call in a claim to New York Life for "topped up" STD benefits (the difference between the statutory benefit and the STD benefit). "Topped up" STD benefits are paid through payroll.

The following information should help you determine if your state has a plan or a program for Disability payments. If you work in one of these locations, New York Life will provide you with information regarding the specific state disability benefits. Please note, however, that statutory disability amounts and agency information are subject to change. The Elimination Period and benefits payable in these states for statutory disability benefits are based on state law.

Associates who work in California must file for statutory disability benefits directly with the state and file for "topped up" STD benefits with New York Life as follows:

California

- You must file for statutory disability benefits directly with the state:
- State of California EDD State Disability Insurance

  English: **1-800-480-3287**

  Spanish: **1-866-658-8846**

  Website: **http://www.edd.ca.gov/Disability/**
- You must file for "topped up" STD benefits with the Disability Claims Administrator:

  New York Life **1-800-828-6352**

Associates who work in Puerto Rico must file for statutory disability benefits directly with the Commonwealth and file for "topped up" STD benefits with New York Life as follows:

Puerto Rico

- Phone 1-787-754-5353
- Website: https://www.trabajo.pr.gov

Associates who work in Rhode Island must file for statutory disability benefits directly with the state, as follows:

Rhode Island

- Disability Determination Services
  1-401-462-8420
  Website: **http://www.dlt.ri.gov/**

Associates who work in New Jersey must file for statutory disability benefits only with the Disability Claims Administrator as follows:

New Jersey

- Disability Claims Administrator:
  New York Life
  1-800-828-6352

EXCLUSIONS AND LIMITATIONS

Except if otherwise required by state law, STD benefits are not paid for:

- Time off for doctor's or dentist's appointments if you are not Disabled.
- Time off for non-medically necessary cosmetic procedures.
- Conditions involving your remaining at home because of appearance or neglect of bodily hygiene.
- Illness/Injury resulting from the use of alcohol or drugs. (However, if you are receiving medical care and treatment for alcoholism or drug addiction, the absence is eligible for STD benefits while you are Disabled and unable to work.)
- Self-inflicted injuries or those that result from participation in riots, fights or other criminal acts.
- Emotional problems, nervousness or mental conditions, unless you are under the care of a Physician or supervision of a psychiatrist, or you are confined to a hospital or institution for treatment of such conditions.
- Work-related Injuries and Illnesses incurred during your assigned work with Transform.
- Situations where you or your Physician(s) refuse to cooperate with Transform or the New York Life case manager.

- Illness/Injury occurring while on leave of absence or while receiving LTD benefits from a Transform-sponsored LTD plan.

STD benefit payments are not necessarily payable for absences due to operations and/or hospital confinements. If the condition for which the operation is performed or the hospital confinement that is required is not a covered Illness or Injury, no disability benefits will be paid for the absence.

Illness and Injuries cease being fully covered if alternate assignments or reduced hours schedules are available that you are able to perform. Should you refuse such assignments, STD benefits will cease.

Dental work should be performed on your own time. Should extensive dental work disable you to the extent that you are unable to perform your job, STD benefits may be paid if your Physician submits documentation to New York Life that supports your inability to work.

Disability benefits will not be paid if appearance is the only disabling factor.

STD benefits are paid entirely by Transform (or the participating affiliate) and can be withheld or terminated by Transform at any time. It is not the intent of Transform to indefinitely subsidize Associates' pay when they are repeatedly absent due to Illness or Injury.

You may not work elsewhere while receiving STD benefits without the advance approval of your manager.

HOW STD BENEFITS ARE PAID

STD benefits under this program are paid through Payroll according to your normal payroll schedule.

Eligible Associates who become ill or injured while on vacation are paid STD benefits instead of vacation pay (vacation days are deferred) if they:

- Have a covered Illness or Injury,
- Are under the care of a Physician,
- Present a statement from the Physician stating the diagnosis and the date they were first treated, and
- Satisfy the Waiting Period, if applicable.

STD benefits, or the tracking of the Waiting Period, will begin the first full day you were absent from scheduled work due to a Disability that is supported by medical documentation from your Physician.

The benefit duration is measured using a seven (7)-day calendar week, not a work week schedule. The STD benefit will not be converted to hours to adjust for a partial day worked or intermittent absences.

For example, assume that New York Life has determined that Pat's disabling medical condition is payable for four (4) weeks beginning on March 1. Pat's STD benefit will begin on March 1 and end on March 29 (4 calendar weeks). If during week 4, Pat is released by the Physician to return to work for three (3) days or 24 hours, week four (4) remains a week of disability, not 24 hours worked. Pat's disability remains compensable through March 29.

WHEN DISABILITY BENEFITS END

Benefits under the STD Program will end upon the earliest of the following to occur:

- You are able to return to work full work schedule with or without medical restrictions;
- You have received the Maximum Benefit;
- Your employment terminates;
- You retire from Transform;
- You die;
- You fail to provide proof of disability; or
- You no longer meet the definition of Disabled.

WAIVER OF WAITING PERIOD

The Waiting Period is waived for a subsequent absence for the same Illness or Injury within four weeks from the date of return from the original absence if the Waiting Period was satisfied during the initial absence.

Subsequent absences due to chronic conditions, such as migraine headaches or asthma, are not considered absences for the same Illness or Injury. For example, each migraine headache is a new Illness, not a continuation of the previous Illness.

ALTERNATE ASSIGNMENTS / REDUCED HOURS SCHEDULES

Illnesses and Injuries cease being fully covered under the STD Program if alternate assignments or reduced hours schedules are available that you are able to perform. Should you refuse such assignments, STD benefits will cease. Associates who can return to work on reduced hours schedules are paid regular pay for hours worked and are paid STD benefits for the balance of their normal weekly work schedule.

ACCIDENTS AT ANOTHER COMPANY

If you are absent from work due to Illness or Injury resulting from employment with another company, you may be eligible, based on state law, to receive Workers Compensation benefits through the other company for time lost from Transform. In these cases, STD benefits are adjusted or eliminated, as applicable. If you do not receive Workers Compensation benefits in such a case, you will be compensated according to the STD Program.

YOUR RIGHTS AND RESPONSIBILITIES

Unless prohibited by law, it is Transform policy to run time off under Transform's STD Program concurrently with time off under the federal Family and Medical Leave Act ("FMLA"), similar state laws, and /or the applicable Transform Leave of Absence policy. Many of the rights and responsibilities that apply under the FMLA, similar state laws and Transform's Family and Medical Leave ("FML"), Associate and Family Leave ("AFL"), and Extended Care Leave ("ECL") policies are independent of and/or in addition to the rights and responsibilities that apply under Transform's STD Program. Additional information about the FMLA may be found in A Notice to

Associates of Rights under FMLA (WHD Publication 1420) at **http://www.dol.gov/whd/regs/compliance/posters/fmla.htm**.

Information regarding Transform's FML, ECL and AFL policies can be found on PeopleDock > Compliance > Centralized Leave Management > Forms and Policies, or contact the CLMT at LEAVE90@transformco.com for more information or contact your manager, or HR representative.

Key responsibilities under the STD Program include, but are not limited to:

- You must give 30 days' advance notice of your need for the absence if your need is foreseeable. If it is not foreseeable, you must give Transform notice as soon as possible by calling the CLMT. Associate
- You must provide medical certification when asked.
- You must file a claim with New York Life and you also must provide the requested medical documentation to them.
- You must submit periodic updates as requested by the CLMT, New York Life, or your HR Representative, as applicable.
- When you are ready to return to work, you must provide a note from your Physician releasing you to return to work, with or without restrictions. If you fail to provide the required release to return to work, you will not be permitted to return to work, and your employment may be terminated.

Similar responsibilities may apply under the FMLA and FML, AFL and ECL policies. Job restoration rights of Associates returning from time off under Transform's STD Program will be governed by applicable leave laws, the applicable leave of absence policy and, as applicable, the Americans with Disabilities Act and similar state laws. For Associates with qualifying disabilities, the company will explore reasonable accommodations. Reasonable accommodations include, but are not limited to, reasonable additional leave, modified duty, modified schedules, part-time work, assistive devices and reassignment.

DIRECT BILLING FOR BENEFIT PAYMENTS

If your STD payments are insufficient to cover your benefit deductions, you may continue your other benefits (for example, medical, dental or vision insurance) by making payments on a post-tax basis. You will receive direct billing information from the Transform Benefits Center and you are responsible for making timely payments for your benefits to prevent a lapse in coverage.

HOW TO FILE A CLAIM FOR BENEFITS

If you believe that you are eligible for STD benefits, you may file a claim for benefits with the claims administrator, New York Life . Contact New York Life at 1-800-828-6352.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If the claims administrator denies your STD claim and you wish to have the decision reviewed, you must submit a written request to the claims administrator for a review of the decision within 180 days of the receipt of the decision. This request should include why you disagree with the claims administrator's decision and any additional medical information that is available.

The appeal should be mailed to the claims administrator at the following address:

New York Life Group Benefit Solutions
P.O. Box 709015
Dallas, TX 75370-9015
Fax: 800-642-8553

The claims administrator will respond within 45 days of the receipt of the appeal. Under special circumstances, an additional 45 days may be required to review the claim. The claims administrator will notify the claimant if an additional 45-day extension is needed.

Notwithstanding the foregoing, appeals regarding the withholding of STD benefits due to failure in qualifying for a leave of absence (as determined by Transform) should be directed to the Transform Benefits Center.

IMPORTANT NOTE

The STD Program is a payroll practice that is exempt from welfare benefit plan status under ERISA. The fact that a summary of this program is included in this Handbook should not be construed as making it an ERISA plan.

FOR MORE INFORMATION

The following additional details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers.
- How to appeal a denied claim.

SOME TERMS YOU SHOULD KNOW

Date of Disability is the date that a new disability begins.

Disabled means you are not able to perform your regular job duties as a result of an Illness or Injury defined below.

Illness means a non-work related illness, including for this purpose pregnancy and childbirth, which disables you to the extent that you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Injury means a non-work related injury sustained in an accident, incurred away from work that disables you to the extent you are unable to perform your regular duties. This includes injuries resulting from employment with another company.

Maximum Benefit is described above in the *Benefit Amount and Duration* section.

Physician means a person who is licensed or otherwise legally authorized to administer medical care or treatment so long as the person is acting within the scope of his/her license or authorization. Physician also means an accredited Christian Science practitioner listed in the current issue of the Christian Science Journal.

Waiting Period is the first fourteen (14) calendar days of an Illness or Injury, including holidays and weekends. STD benefits are not paid during the Waiting Period, and as otherwise described above in the *How the Program Works* and *Benefit Amount and Duration* sections.

Long-Term Disability Program

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ABOUT THE LONG-TERM DISABILITY PROGRAM

If you were unable to work for a long period of time because of a serious Illness or Injury, your paychecks would stop—but you would still have regular living expenses. The Long-Term Disability Program component of the Plan (the "LTD Program") ensures that you'll have a continuing source of income to help meet those expenses throughout a disability. The LTD Program is insured and administered by New York Life. Part-time hourly Associates are not eligible to participate in the LTD Program.

A Survivor Benefit will now be included. This benefit provides a lump sum payment equal to three times the LTD benefit without reduction by deductible income (deductible income would include Social Security benefits provided to the participant, dependent benefits would not be considered deductible income).

Note: Throughout this section, several terms are capitalized. Those terms are defined either in the text of this section or under *Some Terms You Should Know* at the end of this section.

CONTRIBUTIONS

Salaried Associates are automatically enrolled in the LTD Program (as of the first day of the month following their date of hire). Hourly Associates must elect to participate in the LTD Program after becoming eligible if they want coverage. Associates can elect to drop LTD Program coverage at any time. In order to participate in the LTD Program, you are required to pay for coverage. Contributions vary based on your rate of pay, your age as of July 1 of the current plan year and your classification as a salaried or hourly Associate. Your age is calculated annually on the Plan Reclassification Date.

Salaried Associates earning $200,000 or more annually are eligible for an enhanced LTD Program. Additional details regarding the LTD Program are described below under *Enhanced LTD Program for Certain Salaried Associates*. Contributions for the Enhanced LTD Program vary based on your rate of pay and your age as of July 1 of the current plan year. Your age is calculated annually on the Plan Reclassification Date.

HOW THE PROGRAM WORKS

If you become Disabled while employed by Transform as a result of an Illness or Injury, you may be entitled to benefits from the LTD Program after fulfilling a Waiting Period. The "Waiting Period" is the earlier of the exhaustion of short-term disability benefits or 140 days within a 52 week period during which you suffered from the same or related Illness or Injury. You will be entitled to LTD benefits if you:

- Become Disabled as a result of an Illness or Injury;
- Are covered by the LTD Program at the time you become Disabled;
- Remain Disabled throughout the Waiting Period;
- Continue to be Disabled after completing the Waiting Period; and
- Are receiving Appropriate Care and Treatment on a continuing basis from a Physician.

LONG TERM DISABILITY EOI

New York Life (NYL) will require Evidence of Insurability (EOI) for enrollment outside of new-hire and above the guaranteed issue effective January 1, 2025.

Effective January 1, 2024, an EOI will not be required during a life status change.

BENEFIT PAYMENT DURATION

Benefits begin after you complete the Waiting Period and continue as long as you remain Disabled until the end of your Maximum Benefit Period, described under *When Benefits End.*

For purposes of the LTD Program, "Disabled" or "Disability" means: during the Waiting Period and thereafter, you are Incapable of Performing the material duties of any gainful occupation for which you are reasonably qualified based on your training, education and experience.

Salaried Associates:

You are considered Disabled if, solely because of Illness or Injury, you are:

1. Unable to perform the material duties of your Regular Occupation; and
2. Unable to earn more than 80% of your Indexed Earnings from working in your Regular Occupation.

Hourly Associates:

You are considered Disabled if, solely because of Illness or Injury, you are:

1. Unable to perform the material duties of any occupation; and
2. Unable to earn more than 80% of your Indexed Earnings from working in any occupation.

Salaried & Hourly Associates:

After LTD benefits have been payable for 24 months, you are considered Disabled if, solely due to Illness or Injury, you are:

1. Unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; and
2. Unable to earn more than 60% of your Indexed Earnings.

The insurance company will require proof of earnings and continued Disability.

After the Waiting Period, if you are (or are able to be) engaged in any occupation for wage or profit other than

Rehabilitative Employment approved in advance by the insurance company, you are not Disabled.

Medical Evidence

To qualify for benefits under the LTD Program, your Disability must be supported by current medical documentation. You must be under the regular care of a Physician under a course of treatment appropriate for the Disability. You may be asked to undergo a medical examination by a Physician designated by the insurance company. If you cannot or will not provide conclusive medical evidence of Disability, LTD benefits will be denied or discontinued.

Continuation of LTD benefit payments will require ongoing certification of Disability based on updated medical documentation. The insurance company will determine how often you will need to provide updated medical documentation.

Recurring Disabilities

If you complete the Waiting Period, begin to receive LTD benefits, return to Active Work status, and resume your LTD contributions, you may be required to complete another Waiting Period if thereafter you become Disabled again.

This second period of Disability will be treated as a continuing Disability if it:

- Begins within 6 months following your return to Active Work; and
- Is due to the same or related Illness or Injury.

In this case, LTD benefits will resume immediately without a new Waiting Period, and the Maximum Benefit Period will apply to the total benefits in all periods.

Otherwise, the second period of Disability will be treated as a new Disability, and you will need to complete a new Waiting Period before LTD benefits can begin again.

Pre-existing Conditions

A Pre-Existing Condition is an Illness or Injury for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 6 months before his or her most recent effective date of treatment. You will not be entitled to LTD benefits if, for that condition, you took prescribed drugs or medicine or received medical treatment or consultation, medical care or services, or diagnostic tests in the 6 months before you became an LTD Program participant.

However, you will be entitled to LTD benefits for a Pre-Existing Condition if your Disability due to that condition begins 12 or more consecutive months after you become covered by the LTD Program.

Mental and Nervous Disorders

Payment of LTD benefits is limited to a maximum of 24 months for salaried associates earning $200,000 or more, and 12 months for all other associates during your lifetime if a Disability is caused by any one or more of the following conditions:

1. Anxiety disorders
2. Delusional (paranoid) disorders
3. Depressive disorders
4. Eating disorders
5. Mental illness
6. Somatoform disorders (psychosomatic illness)

Once 12 monthly LTD benefits have been paid, no additional LTD benefits will be payable for the above conditions.

If, before reaching your lifetime maximum benefit, you are confined in a hospital, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care and Treatment of any of the conditions listed above.

Alcoholism and Drug Addiction or Abuse

If you are Disabled due to alcohol, drug or substance abuse or dependency, LTD benefits are limited to one period of Disability during your lifetime, but no longer than 24 months for salaried associates earning $200,000 or more, and 12 months for all other associates. You must be participating in a rehabilitation program recommended by a Physician. LTD benefits will not continue beyond completion of a rehabilitation program, nor will they continue if you refuse to participate in a rehabilitation program.

Subjective Symptom Limitation

The Insurance Company will pay Disability Benefits on a limited basis during an Associate's lifetime for a Disability caused by Subjective Symptom condition. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for the following conditions.

Subjective Symptom Conditions means any physical or mental or emotional symptom, feeling or condition reported by the Associate, or by his or her Physician, which cannot be verified using tests, procedures or clinical examinations that conform to generally-accepted medical standards. Subjective Symptom Conditions include, but are not limited to, headaches, pain, fatigue, stiffness, numbness, nausea, dizziness and ringing in ears.

When Benefits End

As long as you remain Disabled, continue under the regular care of a Physician, continue to provide evidence of that Disability to the insurance company, and are not Disabled from a mental and nervous disorder or alcohol, drug, or substance abuse or dependency, LTD benefits will continue until the end of the Maximum Benefit Period that applies to you or until your death, if sooner. **Note**: If

the insurance company approves a rehabilitation program, please refer to the provisions under Rehabilitative Employment. Should you refuse or cease Rehabilitative Employment, LTD benefits will end.

The Maximum Benefit Period that applies to you is the period shown in the right-hand column of the following chart opposite your age at the time benefits under the LTD Program begin for your Disability.

Age When Benefits Begin	Maximum Benefit Period
Less than age 62	To age 65
62 or 63	To age 65 or for 31 months, whichever is later
64, 65 or 66	For 31 months
67	For 31 months, but not beyond age 70
68	To age 70
69 or older	For 12 months

WHEN COVERAGE ENDS

Your coverage ends on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date the Plan or applicable policy is terminated;
3. on the date you are no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date you are no longer in Active Service; or
6. the date benefits end because you did not comply with the terms and conditions of the insurance coverage.

If you are entitled to receive Disability Benefits when the applicable policy terminates, Disability Benefits will be payable to you if you remain disabled and meet the requirements for the insurance. Any later period of Disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

LTD CONTRIBUTIONS DURING DISABILITY

If you become Disabled, you must continue to pay LTD contributions during the Waiting Period. Once you qualify for LTD benefits, you will not have to pay any further LTD contributions during the period in which you receive LTD benefits, beginning on the first day of the month that coincides with or immediately follows the date that benefits become payable.

AMOUNT OF BENEFITS

The amount of the benefit you will receive per year during a period of Disability is based on your Eligible Annual Earnings up to a maximum of $250,000. While you are covered by the LTD Program and before you begin receiving LTD benefits, your Eligible Annual Earnings are calculated annually on the Plan Reclassification Date established by the Plan Administrator. If you are on an approved leave of absence on the Plan Reclassification Date, a recalculation will not be done for you.

INCREASES IN EARNINGS

If your Eligible Annual Earnings have increased since the last time the reclassification calculation was made, the increase will be effective on the next Plan Reclassification Date, at which time you will qualify for a higher amount of LTD benefits. However, the increase will not apply to disabilities commencing before the annual Plan Reclassification Date.

DECREASES IN EARNINGS

If your Eligible Annual Earnings have decreased since the last time the reclassification calculation was made, the decrease will be effective on the next Plan Reclassification Date, at which time you will qualify for a lesser amount of LTD benefits. However, a decrease will not apply to disabilities commencing before that date and will only take effect if your Eligible Annual Earnings have qualified you for a lesser amount of LTD coverage for 2 consecutive years.

Any payroll year in which you were on an approved leave of absence for 2 months or longer will be ignored for purposes of decreases in earnings.

MONTHLY BENEFIT WHILE DISABLED

The amount of the monthly LTD benefit you will receive while you are Disabled is equal to 60% for salaried Associates and 50% for hourly Associates of the first $20,833 of your Monthly LTD Covered Earnings less (a) any Other Income Benefits (defined in a later section to this chapter) to which you are entitled and (b) 50% of your earnings from Rehabilitative Employment, if any.

If necessary, your monthly LTD benefit will be reduced so that the total amount you receive from LTD, Rehabilitative Employment, and Other Income Benefits does not exceed your Monthly LTD Covered Earnings.

If you are eligible for LTD benefits, the maximum amount of monthly LTD benefit you can receive from the LTD Program is $12,500 for salaried Associates and $10,417 for hourly Associates.

If you are eligible for LTD benefits, the minimum amount of monthly LTD benefit you can receive from the LTD Program is $100, unless, the insurance company has made an overpayment of benefits to you or the monthly LTD benefit, including Other Income Benefits plus Rehabilitative Employment earnings, results in earnings exceeding 100% of your Monthly LTD Covered Earnings.

MONTHLY LTD COVERED EARNINGS

Your Monthly LTD Covered Earnings are equal to your Eligible Annual Earnings in effect on the day before your Disability began, rounded to the next higher thousand and divided by 12.

For instance, if your Eligible Annual Earnings fall between $23,000.01 and $24,000.00, your Monthly LTD Covered Earnings are $2,000 ($24,000 divided by 12).

OTHER INCOME BENEFITS

Other Income Benefits you are eligible to receive affect the amount that the LTD Program pays you in monthly LTD benefits.

Other Income Benefits include:

- Any amounts received (or assumed to be received*) by the Associate or his or her dependents under:
    - The Canada and Quebec Pension Plans;
    - The Railroad Retirement Act;
    - Any local, state, provincial or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with Transform; or
    - Any sick leave or salary continuation plan of Transform;
- Any Social Security disability or retirement benefits the Associate or any third party receives (or is assumed to receive*) on his or her dependents; or which his or her dependents receive (or are assumed to receive*) because of his or her entitlement to such benefits;
- Any amounts received (or assumed to be received*) by the Associate or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury of sickness arising out of work with Transform including all permanent and temporary disability benefits; and
- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

**Assumed Receipt of Benefits: The insurance company will assume the Associate (or his or her dependents, if applicable) is receiving benefits for which he or she is eligible from other income benefits.*

All amounts available to you as Other Income Benefits will be used to calculate your monthly LTD benefit, whether or not you actually apply for and receive those amounts.

SOCIAL SECURITY BENEFITS

You can request assistance in applying for Social Security benefits by contacting the insurance company (New York Life).

Often, the approval or denial of a claim for Social Security benefits takes quite a while. Therefore, the insurance company has the right to estimate Social Security benefits during the first 24 months of your Disability benefit period. Included in the estimate will be Social Security benefits for you, your spouse and your children.

However, if not later than 6 months following the date of the first LTD monthly payment, you provide the insurance company with written confirmation from the Social Security Administration that you have applied for Social Security benefits, then your monthly LTD benefit will **not** be reduced by estimated Social Security benefits.

The insurance company will require you to sign an agreement confirming that you will repay them any overpayments caused by receipt of Social Security benefits, including retroactive payments, and authorizing them to obtain information on awards directly from the Social Security Administration.

When the insurance company receives notification of your Social Security award or denial, it may cause a change in the amount of your monthly LTD benefit. If it turns out that the estimate of your Social Security award was too high, the insurance company will recalculate your LTD monthly benefit and pay you amounts owed to you for past months in a lump sum. If the estimate was too low, then you will be required to repay the insurance company for the resulting overpayment.

The insurance company has the right to recover overpayments by applying them against all or part of future LTD benefits until the repaid amount has been recovered.

Once you begin receiving benefits from the LTD Program, your LTD benefit **will not** be reduced to reflect changes in your Social Security disability or retirement benefits due to cost-of-living increases. However, your monthly benefit **will** be adjusted to reflect changes in your Social Security payments due to changes in your marital or family status.

REHABILITATIVE EMPLOYMENT

The LTD Program provides a program designed to help you return to active, permanent work. However, such a program must be approved by the insurance company. Rehabilitation programs may allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program. If you participate in an approved rehabilitation program, your monthly LTD benefit is increased by 10%.

The Rehabilitation Plan will consist of one or more of the following phases:

- Rehabilitation, under which the insurance company may provide, arrange, or authorize educational, vocational, or physical rehabilitation or other appropriate services; and/or
- Work which may include modified work and work on a part-time basis.

You may receive LTD benefits for up to 24 months following the date your Disability ends if the insurance company determines you are no longer Disabled while you are participating in the rehabilitation program if you are not able to find employment.

If you fail to fully cooperate in all required phases of the rehabilitation program and assessment without good cause, no Disability benefits will be paid, and insurance will end.

SOME EXAMPLES

The following examples show how the LTD Program works.

Example 1 – No Other Income Benefits or Rehabilitation Earnings

Assume your Eligible Annual Earnings are $24,000.

Therefore, your Monthly LTD Covered Earnings are $2,000 ($24,000 divided by 12).

Your monthly LTD benefit is calculated as follows:

Salaried: $2,000 x 60% = $1,200 from the LTD Program

Hourly: $2,000 x 50% = $1,000 from the LTD Program

Example 2 – Entitled to Social Security Benefits

Assume your Monthly LTD Covered Earnings are $2,200.

Assume also that you have dependent children; you apply for and receive a family Social Security disability benefit in addition to your individual Social Security disability benefit, totaling $1,050 per month.

Your monthly LTD benefit is calculated as follows:

Salaried:$2,200 x 60% = $1,320

Hourly: $2,200 x 50% = $1,100

minus

your monthly individual and family Social Security disability benefit ($1,050)

equals

Salaried: $270 from the LTD Program

Hourly: $50, however, because there is a $100/month minimum benefit from the LTD Program, you would receive $100/month.

Example 3 – Receiving Rehabilitation Earnings

Assume your Monthly LTD Covered Earnings are $2,200.

Assume also that during Disability after LTD Program benefits begin, you begin earning $1,500 a month from Rehabilitative Employment.

Assume you have no Other Income Benefits.

Your monthly LTD benefit is calculated as follows:

Salaried: $2,200 x 60% = $1,320

Hourly: $2,200 x 50% = $1,100

Plus 10% Rehabilitative incentive:

Example 3 – Receiving Rehabilitation Earnings

Salaried: = 10% x $1,320 = $132

Hourly: 10% x $1,100 = $110

minus

50% of your earnings from Rehabilitative Employment

Salaried & Hourly: $1,500 x 50% = $750

equals

Salaried: $702 from the plan, which is capped at $700 to produce 100% of Monthly LTD Covered Earnings. Therefore, the sum of your total monthly payments from the LTD Program and Rehabilitative Employment would be $2,200 ($700 LTD Program benefits and $1,500 rehabilitative earnings).

Hourly: $460 from the LTD Program. Therefore, the sum of your total monthly payments from the LTD Program and Rehabilitative Employment would be $1,960 ($460 LTD Program benefits and $1,500 rehabilitative earnings).

WHEN BENEFITS ARE NOT PAYABLE

LTD benefits will not be paid if:

- You earn, from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to you at that time;
- The insurance company determines you are not Disabled;
- The end of the Maximum Benefit Period has been reached;
- You die or you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment;
- You are no longer receiving Appropriate Care and Treatment; or
- You fail to cooperate with the insurance company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Additionally, LTD benefits are not paid for disabilities resulting from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane;
- War, or any act of war, whether or not declared.
- Active participation in a riot; or
- Commission of a felony.

ENHANCED LTD PROGRAM FOR CERTAIN SALARIED ASSOCIATES

An enhanced LTD Program for salaried Associates earning $200,000 or more annually is available. The program enhancements include the following items:

- There was a premium reduction under all age bands. See *Contributions* above for the current premium rates.
- Partial disability will be covered beginning with the first day of disability.
- Activities of Daily Living (ADL) benefits will be included. This is an additional benefit that, when added to the LTD benefit, provides income replacement equal to 80% of pre-disability earnings.
- Maximum benefit duration will be your Social Security Normal Retirement Age.

Please contact the Transform Benefits Center at **1-888-887-3277, option 1** for more information.

HOW TO CANCEL COVERAGE

Associates may cancel their coverage at any time by contacting the Transform Benefits Center at **1-888-887-3277, option 1**.

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the LTD Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the LTD Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for LTD coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation – to the Transformco Benefits Department at the following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initial Form where you will see message titled “Your Action Needed” with an electronic claim form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator’s decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan’s appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

If You Have a Benefit Claim

These procedures apply to claims for benefits relating to LTD coverage. It may not be necessary for you to file a claim for LTD benefits if you are receiving STD benefits. Generally, you only have to report your Disability claim once. If payments transition from STD to LTD, you may not need to submit more paperwork.

If it is likely that you will qualify for LTD, your case manager and a Social Security specialist can begin assisting you with the Social Security application process even before you transition to LTD.

If you are not receiving STD benefits, you should call New York Life **1-800-828-6352** to report your claim after you have been out of work for approximately 8 weeks due to a Disability. A claim should be filed prior to completing the Waiting Period, or as soon as is reasonably possible.

The claims administrator will notify you in writing of its initial claims decision. Such notification will be provided within a reasonable period, not to exceed 45 days after receipt of the claim, except that under special circumstances, the claims administrator may have up to two 30-day extensions if needed due to matters beyond the plan's control.

If the claims administrator denies the claim, the written decision will include the following:

- The specific reason(s) for the denial;
- The pertinent plan provision(s) on which the denial is based;
- If an adverse decision is based on advice of medical or vocational experts, the experts whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- If the claim is denied because the claims administrator did not have sufficient information, an explanation that the claim was denied because of insufficient information, and why such information was needed;
- If an internal rule, protocol, guideline, standard or other criteria was relied upon in making the decision, a statement that such rule, protocol, guideline, standard or other criteria was relied upon and that you may request a copy (if a copy is available) free of charge;
- A statement describing any claim and appeal procedures offered by the plan and the time limits applicable to such procedures, as well as a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no cost upon request; and
- For claims submitted on or after April 1, 2020, a discussion of the adverse benefit determination on review including an explanation of the basis for disagreeing with or not following (a) the views presented to the LTD Program of health care professionals treating you or vocational professionals who evaluated you; (b) the views of the medical or vocational experts whose advice was obtained on behalf of the LTD Program, without regard to whether such advice was relied upon; and (c) a Social Security Administration disability determination presented by you to the LTD Program.

Payment of Benefits

Upon approval of your LTD claim, you will be paid all benefits due up until that time (from the day following completion of the Waiting Period through the end of the month before the date of approval) in one lump sum. Subsequent LTD benefit payments will be paid at regular intervals, but not less frequently than monthly. All LTD payments will come directly to you from the insurance company. For each day of a partial month, 1/30 of a full month's benefit is payable. Any LTD benefit balance, unpaid at the end of a period during which you are entitled to LTD benefits, will be paid as soon as administratively feasible.

Benefits will be paid to you, or if you die, any applicable benefits remaining (with respect to a period prior to your death) will be paid to your spouse, if living; otherwise your mother, father, children, brothers or sisters, or to the executors or administrators of you estate.

How to Appeal a Denied Claim For Benefits

If the claims administrator has denied your claim for LTD benefits, you may appeal the decision. You must file a written appeal within 180 days of the claims administrator's decision, assuming that there are not extenuating circumstances, as determined by the claims administrator, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

- Name of Associate;
- Name of the LTD Program;
- Reference to the initial determination; and
- Explain reason why you are appealing the initial determination.

Appeals must be sent to the claims administrator at:

New York Life Group Benefit Solutions
P.O. Box 709015
Dallas, TX 75370-9015
Facsimile: (800) 642-8553

You may submit any additional information to the claims administrator when you submit your request for appeal. You may also request that the claims administrator provide you copies of documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations. Your request must be in writing. Such information will be provided at no cost to you. You will also receive, at no cost and as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination for a Disability claim on review is required to be provided, any new or additional evidence considered, relied upon or generated in connection with your claim and any new or additional rationales forming the basis for the LTD Program's determination of your claim.

After the claims administrator receives your written request to appeal the initial determination, the claims administrator will review your claim de novo, which means the appellate reviewer will look at the claim anew and give no deference to the initial claim decision. The appellate review will take into account all comments, documents, records, etc. submitted to the claims administrator that are related to the claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny the claim. In addition, the person who is reviewing the appeal will not be a subordinate who reports to the person who made the initial decision to deny the claim. If the adverse decision is based in whole or in part on medical judgment, the claims administrator will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

The claims administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request for appellate review, except that under special circumstances, the claims administrator may have up to an additional 45 days to provide written notification of the final decision. If the claims administrator needs such an extension, it will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time for the claims administrator to make a final decision is tolled from the date of the extension notice until the plan receives the requested information. You will have 45 days to provide the requested information from the date you receive the notice of insufficiency from the plan. The initial 45 day time period for the claims administrator to make a final written decision, plus the 45 day extension period (if applicable) are tolled from the date the notification of insufficiency is sent to you until the date on which it receives your response or, if earlier, the expiration of 45 days. The tolling period ends when the claims administrator receives your response, regardless of the adequacy of your response.

If the applicable claims administrator denies the claim on appeal, the claims administrator will send you a final written decision that includes the following:

- The specific reason(s) for the appeal decision;
- The pertinent plan provision(s) on which the denial is based;
- If an adverse decision is based on advice of medical or vocational experts, the experts whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- If the claim is denied because the claims administrator did not have sufficient information, an explanation that the claim was denied because of insufficient information, and why such information was needed.
- If an internal rule, protocol, guideline, standard or other criteria was relied upon in making the decision, a statement that such rule, protocol, guideline, standard or other criteria was relied upon and that you may request a copy (if a copy is available) free of charge;
- A statement that the claimant is entitled to receive, upon request and at no cost, copies of documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations;
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency";
- A discussion of the adverse benefit determination on review including an explanation of the basis for disagreeing with or not following (a) the views presented to the LTD Program of health care professionals treating you or vocational professionals who evaluated you; (b) the views of the medical or vocational experts whose advice was obtained on behalf of the LTD Program, without regard to whether such advice was relied upon; and (c) a Social Security Administration disability determination presented by you to the LTD Program; and

- A statement of your right to bring a civil action under Section 502(a) of ERISA and a description of any applicable plan imposed limitations period, including the calendar date when the limitations period will expire.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

IMPORTANT NOTES

The LTD Program is a welfare benefit plan under ERISA. This section of the Handbook, together with the applicable provisions of the *Introduction* and *Other Information* sections, are intended to constitute an SPD in accordance with ERISA.

The following details about your benefit coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits;
- Coverage continuation for certain benefits; and
- Contact information for benefit claims administrators and insurance carriers.

SOME TERMS YOU SHOULD KNOW

Actively at Work or **Active Work** means you are performing for Transform the duties of your employment at the place and in the manner in which the duties of your employment are usually and customarily performed.

Appropriate Care and Treatment means medical care and treatment that is:

1. Received from a Physician whose medical training and clinical experience are suitable for treating your Disability;
2. Necessary to meet your basic health needs and is of demonstrable medical value;
3. Consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies; and
4. Consistent with the diagnosis of your condition.

The purpose of such medical care and treatment must be to maximize your medical improvement.

Disabled is described above in the *How the Plan Works* section.

Eligible Annual Earnings are your prior payroll year earnings, as determined by established practices of Transform.

Illness means pregnancy or disease that causes deterioration in the state of health of the afflicted person.

Indexed Earnings are equal to covered earnings for the first 12 months. After 12 monthly benefits are payable, Indexed Earnings will be an Associate's covered earnings plus an increase applied to each anniversary of the date monthly benefits became payable. The amount of each increase will be the lesser of: (1) 10% of the Associate's Indexed Earnings during the preceding year of Disability; or (2) the rate of increase in the Consumer Price Index during the preceding calendar year.

Injury means accidental bodily injury.

Maximum Benefit Period is described above in the *How the Plan Works* and *When Benefits End* sections.

Monthly LTD Covered Earnings are equal to your Eligible Annual Earnings in effect on the day before your Disability began, rounded to the next higher thousand, and divided by 12.

Physician means a person who is licensed or otherwise legally authorized to administer medical care or treatment so long as the person is acting within the scope of his/her license or authorization. "Physician" also means an accredited Christian Science practitioner listed in the current issue of the *Christian Science Journal.*

Plan Reclassification Date is the date set by the Plan Administrator. The Plan Reclassification Date is July 1 of each year, unless or until it is changed prospectively by the Plan Administrator.

Pre-Existing Condition is described above in the *How the Plan Works* section.

Regular Occupation is the occupation you routinely perform at the time the Disability begins or any occupation for which you are, or may reasonably become qualified based on education, training, or experience.

Rehabilitative Employment means a type of employment that the insurance company accepts as being employment which is designed to rehabilitate you while you are Disabled and for which you receive wage or profit.

Waiting Period is described above in the *How the Plan Works* section.

Accident Insurance Program

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ABOUT THE ACCIDENT INSURANCE PROGRAM

The Accident Insurance Program component of the Plan (the "Accident Insurance Program") is an excellent complement to your medical coverage. The Accident Insurance Program is designed to help absorb the out-of-pocket medical expenses that arise when injury strikes. You can use the benefits received to offset costs like deductibles, coinsurance, prescription drug expenses and more. The total benefit you receive is based on the type of injury, its severity and the medical services you received in treatment and recovery. The Accident Insurance Program is insured and administered by MetLife and is a limited benefit policy.

CONTRIBUTIONS

You are required to pay contributions for your Accident Insurance. Contributions by active participants are made through payroll deductions on an after-tax basis. The amount of your contributions will vary depending on the number of family members you elect coverage for. The contribution rates are provided to you at the time you become eligible to enroll and during each annual enrollment period.

ELIGIBILITY AND ACCIDENT BENEFITS

The *Introduction* section of the Handbook provides the eligibility rules for the Accident Insurance Program. The eligibility requirements within this Handbook take precedence over the eligibility requirements included in any documents provided to you by the insurance company. While the Handbook sets forth the eligibility rules, it does not fully describe the benefits provided under the Accident Insurance Program. For specific information about the benefits offered and conditions, you will need to consult the applicable Certificate of Insurance and/or group policy for the Accident Insurance Program.

HOW THE PROGRAM WORKS

The Accident Insurance Program provides benefits if you or a covered dependent seek medical treatment or is hospitalized as a result of a Covered Accident. Generally, an accident is a Covered Accident if it occurs as a result of a sudden, unforeseen, and unexpected event that results in an injury and occurs without the injured person's intent. The benefits under the Accident Insurance Program are not reduced by any other benefit you may receive. The Accident Insurance Program can help you pay for things like immediate care treatment, hospitalization, physical therapy, transportation, and lodging. Benefits are paid directly to you.

Features of the Accident Insurance Program include:

- **Lump Sum Benefit:** You receive a set benefit in a lump sum, based on the nature of the accident and care required.
- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** Coverage options are available for your spouse and children.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

BENEFIT AMOUNTS

The Accident Insurance Program provides 24-hour coverage. The benefit amounts shown in the following summary will be paid regardless of actual expenses incurred. Benefits are payable when all terms and conditions, as set forth in the Certificate of Insurance are met.

Benefit Type	Benefit Amount
Fracture	$438-$10,000* depending on the fracture and type of repair
Dislocation	$375 - $7,500* depending on the dislocation and type of repair
Second or Third Degree Burn	$100 - $20,000 depending on the degree of the burn and the percentage of burnt skin
Concussion	$500
Coma	$10,000
Laceration	$25 - $600 depending on the length of the cut and type of repair
Broken Tooth	Crown: $150 / Filling: $75 / Extraction: $150
Eye Injury	$400
Ambulance	Ground: $300 / Air: $1,000
Emergency Care	$250
Physician Follow-Up Visit	$250
Therapy Services (including physical therapy)	$100
Medical Testing	$400
Medical Appliance	$150 ($750 limit for all appliances combined, per person/per accident)
Transportation	$400
Pain Management (for epidural anesthesia)	$75
Prosthetic Device	One device: $1,000 More than one device: $2,000
Blood/Plasma/Platelets	$300

Surgical Repair	$1,000 - $2,000 depending on the type of surgery
Exploratory Surgery	$750
Other Outpatient Surgery	$300
General Anesthesia	$100
Hospital Admission	$2,000 for the day of admission
ICU Supplemental Admission (in addition to Admission benefit)	$2,000 for the day of admission
Confinement (paid for up to 365 days per accident)	$300 per day
ICU Supplemental Confinement (in addition to Admission benefit) (paid for up to 365 days per accident)	$400 per day
Inpatient Rehabilitation (paid for up to 30 days per accident)	$100 per day
Paralysis	$5,000 - $10,000 depending on the number of limbs
Lodging*** (for your companion in the event that you are hospitalized) (up to 30 days per covered person per calendar year)	$100 per day
Child Care (for your child in the event that you are hospitalized) (5 days per Accident; up to 10 days per calendar year	$75 per day
Health Screening**	$75 paid once per calendar year for completing one of the screenings
Waiver of Premium if You Become Disabled	Included

*Chip fractures and partial dislocations are paid at 25% of the applicable fracture or dislocation benefit

**The coverage for these benefits depends on your state of residence. Contact MetLife for state specific information.

***Lodging must be at least 50 miles from your primary residence.

All amounts in the above chart are increased by 40% if the accident occurred while you were playing in an organized sport.

CHOOSING A COVERAGE LEVEL

When you enroll for Accident insurance, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse
- Associate + child(ren) or
- Associate + family

CONTINUATION OF INSURANCE

If you leave the Company or retire, you and your covered dependents can continue 100% of your coverage. Coverage may continue up to age 26 for dependent child, unless otherwise specified. Rates may be higher than you paid as an active Associate and are subject to change.

IMPORTANT DEFINITIONS & POLICY PROVISIONS

COVERAGE TYPE

Benefits are paid when a Covered Injury results, directly and independently of all other causes, from a Covered Accident.

COVERED ACCIDENT

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the Covered Person is insured under the Accident Insurance Program; is not contributed to by disease, sickness, mental or bodily infirmity; and is not otherwise excluded under the terms of the Accident Insurance Program, as further described in the Certificate of Insurance.

COVERED INJURY

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

COVERED PERSON

An eligible person who is enrolled for coverage under the Accident Insurance Program.

COVERED LOSS

A loss that is the result, directly and independently of other causes, from a Covered Accident suffered by the Covered Person within the applicable time period described in the Certificate of Insurance for the Accident Insurance Program.

HOSPITAL

An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of medical doctors; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis, and charges for its services. The term Hospital does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial,

educational, or nursing care; the aged, treatment of drug or alcohol addiction.

WHEN YOUR COVERAGE BEGINS

Coverage begins on the later of the Accident Insurance Program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by MetLife. Your coverage will not begin on the effective date if hospital, facility or home confined disabled or receiving disability benefits or unable to perform activities of daily living.

WHEN YOUR COVERAGE ENDS

Coverage ends on the last day of the month in which you are actively employed, earliest of the date you and your dependents are no longer eligible, the date the group policy for the Accident Insurance Program is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible.

BENEFIT CONDITIONS AND LIMITATIONS

The following is general information about the exceptions and limitations that may apply to the benefits described. This is not a complete list of policy terms and conditions. Your actual policy may vary by plan design and location. See your Certificate of Insurance for more information, including state mandated benefits. All claims for a Covered Loss must meet specific benefit conditions and limitations and are otherwise subject to all terms set forth in the group policy and the Certificate of Insurance.

EXCLUSIONS*

In addition to any benefit-specific exclusions, no payments will be made for any loss which, directly or indirectly, is caused by or results from: (a) intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; (b) commission or attempt to commit a felony or an assault; (c) declared or undeclared war or act of war; (d) active duty service in the military, naval or air force of any country or international organization; (e) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless taken as prescribed by a physician; (f) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant; (g) bungee jumping; parachuting; skydiving; parasailing; hang gliding; (h) flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface (except as a fare-paying passenger on a regularly scheduled commercial airline); (i) services or treatment rendered by a health care provider who is: Employed, retained by, related to, or living with the covered person; providing homeopathic, aroma therapeutic or herbal therapeutic services; or (j) sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof (except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food).

SPECIFIC BENEFIT EXCLUSIONS & LIMITATIONS*

**Exclusions and limitations that vary by state are identified with an asterisk.*

- **Blood / Plasma / Platelets:** Must be prescribed by a physician on an emergency basis or provided while the insured is undergoing surgery and must be administered within 180 days after the accident.
- **Broken Tooth:** No more than 1 crown, filling or extraction will be paid regardless of the number of teeth involved.
- **Burns*:** Excludes first degree burns.
- **Coma*:** Must be unconscious for 7 days or more with no response to commands, including eye opening; verbal response; and motor response.
- **Dislocation:** If more than 1 dislocation, no more than two times the highest benefit will be paid for all dislocations combined.
- **Follow-up Physician Office and Therapy Service Visits:** Must be recommended by a physician. Treatment must begin within 180 days after the accident occurs and be provided within 365 days after the accident occurs.
- **Fracture:** If more than 1 fracture, no more than two times the highest benefit will be paid for all fractures combined. If fracture is treated with both open and closed reduction, only the open reduction benefit will be paid.
- **Hospital Admission:** Must be admitted as an inpatient due to a Covered Accident. Excludes: Treatment in an emergency room, provided on an outpatient basis, or a stay of less than 20 hours. Paid no more than one time per accident.
- **Hospital Confinement:** Confinement must begin within 180 days after the accident occurs, is payable for up to 365 days and may be used over a two-year period following the date of the accident.
- **ICU Supplemental Admission:** Must be admitted to an ICU unit at initial hospital admission.
- **ICU Supplemental Confinement:** Confinement must begin within 180 days after the accident and is payable for up to 365 days (paid in addition to the Hospital Confinement benefit)
- **Lacerations:** If more than 1 laceration; benefit paid is based on total length of all lacerations that require repair with stitches.
- **Medical Appliance:** Must be prescribed by a physician and use must begin within 180 days after the accident occurs. (Not payable for the replacement of a medical appliance.)

- **Pain Management (for Epidural Anesthesia):** Must be prescribed by a physician and be administered within 180 days after the accident occurs.
- **Paralysis*:** If more than 1 benefit is payable, only the largest available benefit will be paid.
- **Prosthetic Device:** Device must be received within 365 days after the accident occurs. (Not payable for replacement of a device, device for the same body part or for a joint replacement, such as an artificial hip or knee.)
- **Transportation*:** Benefits will not be payable if ambulance benefit is paid.
- **Other:**
    - Requires admissions, stays, surgery, diagnostic exams, diagnosis, visits, ambulance trips, or treatment to be within 90 days of a Covered Accident. Emergency care within 30 days
    - If eligible for physician office or emergency care benefits for the same Covered Accident, only 1 benefit will be payable, whichever is greater. Not eligible for physician office benefit if eligible to receive benefits under emergency treatment.
    - *Some benefits require stays, treatment, services or items to be diagnosed, performed, prescribed or recommended by a physician. For dental services, they must be performed by a licensed dentist.
    - *Requires surgery, treatment, grafting, diagnosis, purchases, extractions, transfusions, or exams to be within 180 days of a Covered Accident

CLAIMS INFORMATION

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Accident Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Accident Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled “Your Action Needed” with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator’s decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan’s appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above,. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

The following information will help you to better understand the claim review and appeal process with respect to the Accident Insurance Program. Standard policy provisions call for the notification of claims from within 31 days of the date of the accident and "proof of accident" within 90 days. Claims outside of these time frames will still be evaluated for their timeliness, but must be reported within one year from their required 90 days "proof of accident". Completed claim and disclosure authorization forms can be found online at

www.mybenefits.metlife.comClaims should be reported as soon as possible by using one of the following methods.

- **Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.**
- **Fax** documents to **1-855-306-7350**
- **Submit a claim online by visiting mybenefits.metlife.com or download the MetLife Mobile App**
- **Mail** documents to:

  Metropolitan Life Insurance Company
  Attn: Accident Insurance
  P.O. Box 80826 Lincoln, NE 68501-0826

PAYMENT OF BENEFITS

Upon approval of your claim, you will be notified of the benefits paid. If any benefits have been denied, a written explanation will be provided. If you claim is denied, you will receive an explanation of benefits (EOB) or letter with instructions on how to appeal the denial.

Benefits are paid directly to the covered person, unless otherwise agreed upon.

HOW TO APPEAL A DENIED CLAIM

If the claims administrator has denied your claim for Accident benefits, you may appeal the decision. You must file a written appeal within 180 days of the claims administrator's decision. Appeals must be in writing and must include the following information:

- Name of Associate;
- Reference to the initial determination; and
- Reason explaining why you are appealing the initial determination.

Appeals must be sent to the claims administrator at:

MetLife
P.O. Box 80826 Lincoln,

NE 68501-0826
Fax: 1-**855-306-7350**

You must submit any additional information to the claims administrator when you submit your request for appeal. You may also request that the claims administrator provide you copies of the documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations. Your request must be in writing. Such information will be provided to no cost to you.

The claims administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request, except under special circumstance, the claims administrator may have up to an additional 45 days to provide written notification of the final decision. If the claims administrator needs such an extension, it will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time for the claims administrator to make a final decision is tolled from the date of the extension notice until the plan receives the requested information. You will have 45 days to provide the requested information from the date you receive the notice of insufficiency from the plan. The initial 45 day time period for the claims administrator to make a final written decision, plus the 45 day extension period (if applicable) are tolled from the date the notification of insufficiency is sent to you until the date on which it receives your response or, if earlier, the expiration of 45 days. The tolling period ends when the claims administrator receives your response, regardless of the adequacy of your response.

If the applicable claims administrator denies the claim on appeal, the claims administrator will send you a final written decision that includes the following:

- The specific reason(s) for the appeal decision;
- The pertinent plan provision(s) on which the denial is based;
- If an adverse decision is based on advice of medical or vocational experts, the experts whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;

- If the claim is denied because the claims administrator did not have sufficient information, an explanation that the claim was denied because of insufficient information, and why such information was needed.
- If an internal rule, protocol, guideline, standard or other criteria was relied upon in making the decision, a statement that such rule, protocol, guideline, standard or other criteria was relied upon and that you may request a copy (if a copy is available) free of charge;
- A statement that the claimant is entitled to receive, upon request and at no cost, copies of documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations;
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency”.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

IMPORTANT NOTE

The Accident Insurance Program is a welfare benefit under ERISA. This section of the Handbook, together with the applicable provisions in the *Introduction* and *Other Information* section, are intended to constitute an SPD for the Accident Insurance Program with ERISA.

All benefits and coverage described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.

Critical Illness Insurance Program

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ABOUT THE CRITICAL ILLNESS INSURANCE PROGRAM

The Critical Illness Insurance Program component of the Plan (the "Critical Illness Insurance Program") can supplement your medical coverage and provide you and your family with the coverage and additional financial protection you may need for expenses associated with an unplanned Covered Condition. This Critical Illness Insurance Program is designed to help absorb the out-of-pocket costs of a serious illness. You can use the benefits received to offset costs like deductibles, coinsurance, expenses your family incurs to be by your side, or simply to replace lost earnings from being out of work. The total benefit you receive is based on the benefit amount elected and covered condition. The Critical Illness Insurance Program is insured and administered by MetLife and is a limited benefit policy.

CONTRIBUTIONS

You are required to pay contributions for your Critical Illness Insurance. Contributions by active participants are made through payroll deductions on an after-tax basis. The amount of your contributions will vary depending on the number of family members you elect coverage for. The contribution rates are provided to you at the time you become eligible to enroll and during each annual enrollment period.

ELIGIBILITY AND CRITICAL ILLNESS BENEFITS

The *Introduction* section of the Handbook provides the eligibility rules for the Critical Illness Insurance Program. The eligibility requirements within this Handbook take precedence over the eligibility requirements included in any documents provided to you by the insurance company. While the Handbook sets forth the eligibility rules, it does not fully describe the actual Critical Illness Insurance Program. For specific information about the benefits offered and conditions, you will need to consult the applicable Certificate of Insurance, Summary and/or group policy for the Critical Illness Insurance Program.

HOW THE PROGRAM WORKS

The Critical Illness Insurance Program provides a direct benefit if you or any covered dependents are diagnosed with a Covered Condition. The Critical Illness Insurance Program pays benefits regardless of, and in addition to, any other insurance you may have. Coverage is available in $10,000 increments up to a maximum of $30,000 with no proof of good health required. Coverage is guaranteed provided you are actively at work and your dependent is not subject to a medial restriction.

Features of the Critical Illness Insurance Program include:

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** Coverage options are available for your spouse and children.
- **Health Screening Benefit:** The program provides a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel, and more.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

AVAILABLE COVERAGE

The benefit amounts shown below will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions and limitations applicable to these benefits. For more information, refer to the Summary and your Certificate of Insurance. All Covered Conditions must be due to disease or sickness.

Eligible Individual	Benefit Amount	
Associate	$10,000, $20,000, $30,000	
Spouse	100% of Associate's initial amount	
Children	50% of Associate's initial amount	

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Autism Spectrum Disorder	100%	None
Benign Brain Tumor	100%	100%
Cancer Invasive Cancer Non-Invasive Cancer Skin Cancer	 100% 25% 25%*,	 100% %100% 100%*
Coronary Artery Bypass Graft (CABG)	100%	100%
Childhood Disease**	100%	None
Occupational Hepatitis or HIV	100%	None
Progressive Disease***	100%***	None
Functional Loss Coma Loss of: ability to speak, hear or see Paralysis: 2 or more limbs	 100% 100% 100%	 100% None 100%
Heart Attack	100%	100%

Sudden Cardiac Arrest	100%	None
Infectious Disease****	25%	None
Kidney Failure	100%	100%
Major Organ Transplant (bone marrow, heart, lungs, pancreas, and liver	100%	100%
Severe Burn	100%	100%
Stroke	100%	100%
Aneurysm	25%	100%
Pulmonary Embolism	25%	100%
Health Screening	$50 for one screening per year	
Lodging	$100 per day for up to 20 days per year	
Transportation	$0.50 per mile up to $1,500 per trip up to $5,000 per year	
NCI Cancer Center	$500 per evaluation and an additional $250 if the Center is more than 50 miles from insured's primary residence	

*No less than $250

**Childhood disease includes the following: Cerebral Palsy, Cleft Lip or Cleft Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes (Type 1), Down Syndrome, Gaucher Disease (Type 2 or Type 3), Glycogen Storage Disease (Type IV), Infantile Tay Sachs Disease, Niemann-Pick Disease, Pompe Disease, Sickle Cell Anemia, Spina Bifida, Zellweger Syndrome.

***Addison's Disease, ALS, Alzheimer's Disease, Huntington's Disease, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Parkinson's Disease (Advanced), Poliomyelitis (initial benefit amount is 25%), Systemic Lupus Erythematosus, Systemic Sclerosis.

****For a benefit to be payable, you or your dependent must have been treated for one of the following diseases in a hospital for 5 consecutive days: Bacterial Cerebrospinal Meningitis, COVID-19, Diphtheria, Ebola, Encephalitis, Legionnaire's Disease, Lyme Disease, Malaria, Methicillin-Resistant Staphylococcus Aureus, Necrotizing Fasciitis, Osteomyelitis (initial benefit amount is 100%), Rabies, Sepsis, Tetanus, Tuberculosis, Variant Creutzfeldt-Jakob Disease.

CHOOSING A COVERAGE LEVEL

When you enroll for Critical Illness insurance, you will select a coverage level ($10,000, $20,000 or $30,000) and the eligible family members you wish to cover:

- Associate only
- Associate + spouse
- Associate + child(ren) or
- Associate + family

PORTABILITY OPTION

If you leave the Company or retire, you and your covered dependents can continue 100% of your coverage. Coverage may continue up to age 26 for dependent child, unless otherwise specified. Rates may change.

IMPORTANT DEFINITIONS & POLICY PROVISIONS

COVERED PERSON

An eligible person who is enrolled for coverage under the Critical Illness Insurance Program.

COVERED LOSS

A loss that is specified in the Schedule of Benefits section of the group policy for the Critical Illness Insurance Program and suffered by the Covered Person within the applicable time period described in the group policy.

GUARANTEED ISSUE

All coverage amounts are guaranteed issue

WHEN YOU COVERAGE BEGINS

Coverage begins on the later of the Critical Illness Insurance Program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by the insurance company. Your coverage will not begin on the effective date if you are in a hospital, facility or are disabled and confined to your home or are receiving disability benefits or unable to perform activities of daily living.

WHEN YOUR COVERAGE ENDS

Coverage ends on the last day of the month in which you are an active employee, your dependents are no longer eligible, the date the group policy for the Critical Illness Insurance Company is no longer in force, or the date for the last period for which required premiums are paid. For your dependents, coverage also ends on the last day of the month in which your coverage ends, when their premiums are not paid or when they are no longer eligible.

BENEFIT REDUCTIONS, COMMON EXCLUSIONS & LIMITATIONS

The following is general information about the exceptions and limitations that may apply to the benefits described. This is not a complete list of policy terms and conditions. Your actual policy may vary by plan design and location. See your Certificate of Insurance for more information, including state mandated benefits. All claims for a Covered Loss must meet specific benefit conditions and limitations and are otherwise subject to

all terms set forth in the group policy and the Certificate of Insurance.

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss that is caused directly or indirectly, in whole or in part by any of the following: (a) intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; (b) commission or attempt to commit a felony or an assault; (c) declared or undeclared war or act of war; (d) a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization (upon our receipt of proof of service, we will refund any premium paid for this time; Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days); (e) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; (f) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant ("under the influence of alcohol'', for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred); or (g) a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

SPECIFIC DEFINITIONS, BENEFIT EXCLUSIONS & LIMITATIONS

The date of diagnosis must occur while coverage is in force and the condition definition must be satisfied. Only one Initial Benefit will be paid for each Covered Condition per person and benefits will be subject to separation periods and Maximum Lifetime Limits, as set forth in the Certificate of Coverage or group policy.

- **Skin Cancer**, basal cell/squamous cell carcinoma or certain forms of melanoma.**Invasive Cancer**, uncontrollable/abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Includes: a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness; a cancer that is a leukemia or lymphoma; or where a covered person has terminal cancer and has a life expectancy of 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy.
- **Non-Invasive Cancer (including Carcinoma in Situ),** the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Includes: a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness; a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or; a Carcinoma in Situ classified as TisN0M0. Non-Invasive Cancer does not include Skin Cancer.
- **Heart Attack**, **Myocardial Infarction** – documentation showing elevation of enzymes, troponins or other biochemical cardiac markers; and two of the three following criteria: (1) confinement in a hospital as an inpatient; (2) documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the covered person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the covered person had any prior electrocardiogram(s), the electrocardiogram(s) presented as proof of Myocardial Infarction must show changes from the covered person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or (3) documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the covered person had any prior imaging studies, the imaging studies presented as proof of Myocardial Infarction must show changes from the covered person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.
- **Sudden Cardiac Arrest** - documentation that shows that the Sudden Cardiac Arrest was caused by any of the following, or that the covered person had a documented medical history of any of the following: coronary artery disease; Myocardial Infarction; myocarditis; cardiomyopathy; valvular heart disease; congenital heart disease; or cardiac electrical conduction abnormalities.
- **Stroke**, cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue: hemorrhage; thrombus; or embolus from an extra-cranial source. The term Stroke does not include Transient Ischemic Attacks, or prolonged reversible ischemic attacks).
- **Coronary Artery Disease**, where the arteries of the heart are damaged or diseased, valves of the heart are damaged or diseased, or there is impaired cardiac function due to the presence of plaques, or fatty deposit, buildup on the artery walls that has caused narrowing of the coronary arteries resulting in partial or complete blockage of the arteries; and a treatment listed below is required to treat the coronary artery disease: Coronary Artery Bypass Graft. Coronary Artery Bypass Graft does not include: Coronary Angioplasty; coronary angiography; or any other intra-catheter technique.
- **Alzheimer's Disease**, progressive Cognitive Disturbances that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information).

- **Amyotrophic Lateral Sclerosis** (ALS or Lou Gehrig's Disease.
- **Parkinson's Disease (Advanced)**, slowly progressive neurological condition affecting the brain's ability to produce dopamine and that is marked by tremor of the muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait which has resulted in a covered person's inability to perform at least 2 Activities of Daily Living for a continuous period of 90 days.
- **Multiple Sclerosis**, progressive neurological condition with evidence of all of the following: well-defined neurological abnormalities lasting more than a continuous period of 6 months confirmed by neurological exam; presence of demyelination in at least two separate areas of the central nervous system; evidence that such demyelination damage took place at different points in time; and diagnostic testing results that document the following: magnetic resonance imaging (MRI) that show T2 – weighted lesions; an abnormal response on evoked potential testing; or oligoclonal antibodies or a high immunoglobulin (IgG) index present in cerebrospinal fluid. Multiple Sclerosis does not include clinically isolated syndrome (CIS).
- **Benign Brain Tumor**, presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.
- **Blindness**, loss of sight in both eyes. With correction, visual acuity must be 20/200 or worse in both eyes, or the field of vision must be less than 20 degrees in both eyes. Loss of sight does not include blindness or loss of sight in one eye due to a previous existing blindness in the other eye.
- **Coma**, continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, as confirmed by a Physician and characterized by the absence of purposeful response to commands, including: eye opening; verbal response; and motor response. Coma does not include a medically induced Coma.
- **Kidney Failure:** end stage, irreversible failure of all functioning kidneys, requiring either: immediate and regular kidney dialysis (no less often than weekly) that is expected to continue for at least 6 months; or a kidney transplant.
- **Major Organ Transplant:** includes: liver, lung, pancreas, heart or bone marrow. Happens when physician determines transplant is medically necessary and Covered Person is placed on the transplant list; or the transplant procedure has been performed. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable.
- **Paralysis**, total and irrevocable loss of extremity movement affecting 2 or more limbs that has lasted not less than 90 consecutive days, and is expected to be permanent; or is a result of a transected spinal cord with supporting clinical and radiological evidence and no expectation of a return to function.
- **Severe Burn,** a burn that is, at least, a Third-Degree Burn.

CLAIMS INFORMATION

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Critical Illness Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Critical Illness Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at the following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;

- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

The following information will help you to better understand the claim review and appeal process with respect to Critical Illness Insurance Program. Standard policy provisions call for the notification of claims from within 31 days of the date of the diagnosis and "proof of diagnosis" within 90 days. Claims outside of these time frames will still be evaluated for their timeliness, but must be reported within one year from their required 90 days "proof of diagnosis". Completed claim and disclosure authorization forms can be found online at mybenefits.metlife.com.

Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: mybenefits.metlife.com.

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826 Lincoln, NE 68501-0826

PAYMENT OF BENEFITS

Upon approval of your claim, you will be notified of the benefits paid. If any benefits have been denied, a written explanation will be provided. If you claim is denied, you will receive an explanation of benefits (EOB) or letter with instructions on how to appeal the denial.

Benefits are paid directly to the covered person, unless otherwise agreed upon.

HOW TO APPEAL A DENIED CLAIM

If the claims administrator has denied your claim for Critical Illness benefits, you may appeal the decision. You must file a written appeal within 180 days of the claims administrator's decision. Appeals must be in writing and must include the following information:

- Name of Associate;
- Reference to the initial determination; and
- Reason explaining why you are appealing the initial determination.

Appeals must be sent to the claims administrator at:

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826 Lincoln, NE 68501-0826

You must submit any additional information to the claims administrator when you submit your request for appeal. You may also request that the claims administrator provide you copies of the documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations. Your request must be in writing. Such information will be provided to no cost to you.

The claims administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request, except under special circumstance, the claims administrator may have up to an additional 45 days to provide written notification of the final decision. If the claims administrator needs such an extension, it will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time for the claims administrator to make a final decision is tolled from the date of the extension notice until the plan receives the requested information. You will have 45 days to provide the requested information from the date you receive the notice of insufficiency from the plan. The initial 45 day time period for the claims administrator to make a final

written decision, plus the 45 day extension period (if applicable) are tolled from the date the notification of insufficiency is sent to you until the date on which it receives your response or, if earlier, the expiration of 45 days. The tolling period ends when the claims administrator receives your response, regardless of the adequacy of your response.

If the applicable claims administrator denies the claim on appeal, the claims administrator will send you a final written decision that includes the following:

- The specific reason(s) for the appeal decision;
- The pertinent plan provision(s) on which the denial is based;
- If an adverse decision is based on advice of medical or vocational experts, the experts whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- If the claim is denied because the claims administrator did not have sufficient information, an explanation that the claim was denied because of insufficient information, and why such information was needed.
- If an internal rule, protocol, guideline, standard or other criteria was relied upon in making the decision, a statement that such rule, protocol, guideline, standard or other criteria was relied upon and that you may request a copy (if a copy is available) free of charge;
- A statement that the claimant is entitled to receive, upon request and at no cost, copies of documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations;
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency”.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

IMPORTANT NOTE

The Critical Illness Insurance Program is a welfare benefit under ERISA. This section of the Handbook, together with the applicable provisions in the Introduction and Other Information section, are intended to constitute an SPD for the Critical Illness Insurance Program with ERISA.

All benefits and coverage described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.

Hospital Indemnity Insurance Program

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ABOUT THE HOSPITAL INDEMNITY INSURANCE PROGRAM

The Hospital Indemnity Insurance Program component of the Plan (the "Hospital Indemnity Insurance Program") can complement your medical coverage. It can provide you and your family with the coverage and additional financial protection you may need for expenses associated with a qualifying hospitalization. You can use the benefits received to offset costs like deductibles, coinsurance, and more. Hospital Indemnity coverage provides a benefit according to the schedule below when a Covered Person incurs a Hospital stay resulting from a Covered Injury or Covered Illness. The Hospital Indemnity Insurance Program is insured and administered by Life Insurance Company of North America (referred to as "MetLife" or the "insurance company" in this section) and is a limited benefit policy.

CONTRIBUTIONS

You are required to pay contributions for your Hospital Indemnity Insurance. Contributions by active participants are made through payroll deductions on an after-tax basis. The amount of your contributions will vary depending on the number of family members you elect coverage for. The contribution rates are provided to you at the time you become eligible to enroll and during each annual enrollment period.

ELIGIBILITY AND HOSPITAL INDEMNITY BENEFITS

The Introduction section of the Handbook provides the eligibility rules for the Hospital Indemnity Insurance Program. The eligibility requirements within this Handbook take precedence over the eligibility requirements included in any documents provided to you by the insurance company. While the Handbook sets forth the eligibility rules, it does not fully describe the benefits provided under the Hospital Indemnity Insurance Program. For specific information about the benefits offered and conditions, you will need to consult the applicable Certificate of Insurance and/or group policy for the Hospital Indemnity Insurance Program.

HOW THE PROGRAM WORKS

The Hospital Indemnity Insurance Program provides benefits if you or a covered dependent is hospitalized as a result of a Covered Accident or Covered Illness. Coverage continues after the first hospital stay so you have additional protection for future hospital stays. The benefits under the Hospital Indemnity Insurance Program are not reduced by any other benefit you may receive. The Hospital Indemnity Insurance Program can help you pay for things like bills not covered by your health plan, child care, travel or other out-of-pocket expenses. Benefits are paid directly to you.

Features of the Hospital Indemnity Insurance Program include:

- Guaranteed Acceptance: There are no health questions or physical exams required.
- Family Coverage: Coverage options are available for your spouse and children.
- Portable Coverage: You can take your policy with you if you change jobs or retire.

BENEFIT AMOUNTS

The Hospital Indemnity Insurance provides 24-hour coverage. The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred and are paid on a per day basis unless otherwise specified. Benefits are only payable when all terms and conditions, as set forth in the Certificate of Insurance are met.

Benefit		Amount
Hospital Admission	1 time per sickness/injury*	$1,000**
ICU Supplemental Admission	1 time per sickness/injury	$2,000
Hospital Confinement***	365 days per calendar year	$200
ICU Supplemental Confinement	Additional benefit for 30 out of 365 days per calendar year	$400
Confinement for Newborn Nursery Care	2 days per confinement	$200
Inpatient Rehabilitation	30 days per calendar year	$200
Ambulance	1 time per calendar year	Ground: $25
Emergency Room	1 time per calendar year	$200
Urgent Care Facility	1 time per calendar year	$200
Health Screening	1 time per calendar year	$75

* If readmitted within 30 days for the same or related sickness/injury for which an Admission Benefit was paid, an additional Admission Benefit is not payable.

**$1,250 for Idaho residents.

***Payable the day of admission.

CHOOSING A COVERAGE LEVEL

When you enroll for Hospital Indemnity Insurance, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse
- Associate + child(ren) or
- Associate + family

CONTINUATION OF INSURANCE

If you leave the Company or retire, you and your covered dependents can continue 100% of your coverage. Coverage may continue up to age 26 for dependent child, unless otherwise specified. Rates may be higher than you paid as an active Associate and are subject to change.

IMPORTANT DEFINITIONS & POLICY INFORMATION

BENEFITS AMOUNT PAYABLE

Benefits for all Covered Persons are payable at 100% of the Benefits Amounts shown, unless otherwise stated.

SICKNESS

A physical illness, physical infirmity or physical disease; Complications of Pregnancy; or Routine Childbirth. Sickness does not include routine pregnancy.

INJURY

Any bodily harm that results directly from an Accident.

COVERED PERSON

An eligible person who is enrolled for coverage under the Hospital Indemnity Insurance Program.

HOSPITAL

A short-term, acute care, general facility which is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons; has organized departments of medicine; has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital; has a requirement that every patient must be under the care of a Physician or dentist; provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); is duly licensed by the agency responsible for licensing such Hospitals; and is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

The term Hospital does not include a separate unit of a Hospital that is licensed as a hospice facility, nursing home, skilled nursing facility, assisted living facility, rehabilitation facility or an outpatient Surgery facility.

WHEN YOUR COVERAGE BEGINS

Coverage begins on the later of the Hospital Indemnity Insurance Program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by MetLife. Your coverage will not begin on the effective date if you are not actively at work on the date insurance would otherwise take effect, insurance will take effect on the date you return to active work.

WHEN YOUR COVERAGE ENDS

Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy for the Hospital Indemnity Insurance Program is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible.

BENEFIT CONDITIONS AND LIMITATIONS

The following is general information about the exceptions and limitations that may apply to the benefits described. This is not a complete list of policy terms and conditions. Your actual policy may vary by plan design and location. See your Certificate of Insurance for more information, including state mandated benefits. All claims must meet specific benefit conditions and limitations and are otherwise subject to all terms set forth in the group policy and the Certificate of Insurance.

EXCLUSIONS*

In addition to any benefit-specific exclusions, no payments will be made for any loss which, directly or indirectly, is caused by or results from: (a) intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; (b) commission or attempt to commit a felony or an assault; (c) declared or undeclared war or act of war; (d) active duty service in the military, naval or air force of any country or international organization; (e) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless taken as prescribed by a physician; (f) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant; (g) unnecessary stays as determined in accordance with generally accepted standards of medical practice, for the diagnosis, care or treatment of the physical or mental condition; (h) elective or cosmetic surgery – does not include reconstructive cosmetic surgery; (i) dental surgery, unless the surgery is the result of an accidental injury; (j) benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Subscriber or providing homeopathic, aroma-therapeutic or herbal therapeutic services or lining in the Covered Person's household or a parent, sibling, spouse or child of the Covered Person.

SPECIFIC BENEFIT EXCLUSIONS & LIMITATIONS (HOSPITAL CARE)*

*Exclusions and limitations that vary by state are identified with an asterisk.

- Hospital Admission: Must be admitted for Confinement to a Hospital for treatment of an Injury or Sickness Excludes: Treatment in an emergency room, provided on an outpatient basis, or a stay of less than 20 hours. If covered person is discharged from confinement for which an Admission Benefit was paid and is confined again within 30 days for the same or related Injury or Sickness, an additional Admission Benefit will not be paid.
- ICU Supplemental Admission: Must be admitted to an ICU unit at initial hospital admission. Paid in addition to the Hospital Admission benefit.
- Hospital Confinement: Must be confined in a hospital for treatment of an Injury or Sickness.
    - ICU Supplemental Confinement: Must be confined in an ICU for treatment of an Injury or Sickness. Paid in addition to the Hospital Confinement benefit. Inpatient Rehabilitation: Must be transferred to a Rehabilitation Facility, as a resident inpatient, immediately after a period of Confinement for treatment of an Injury or Sickness for which an Admission Benefit or Confinement was paid.
    - Newborn Nursery Care: Routine well baby care provided while Confined immediately following a Covered Person's childbirth of such baby. If newborn is confined for treatment of a physical illness, infirmity, disease or Injury, the Hospital Confinement benefit will be paid instead of the Newborn Nursery Care.
    - Ambulance Benefit: Applies to ground ambulance transport for the day on which a licensed professional ambulance service is required to transport a Covered Person by ground to or from a Hospital or between medical facilities, where treatment for an Injury or a Sickness is received.
    - Emergency Room/Urgent Care Facility: Must receive emergency care for initial treatment of an Injury or Sickness from a Physician in an Emergency Room or an Urgent Care Facility. For treatment of an injury the emergency care must be received within 48 hours after the Accident occurs.
    - **Health Screening Benefit:** The program provides a $75 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel, and more.

CLAIMS INFORMATION

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Hospital Indemnity Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Hospital Indemnity Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the If You Have a Benefit Claim provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;

- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

The following information will help you to better understand the claim review and appeal process with respect to the Hospital Indemnity Insurance Program. Standard policy provisions call for the notification of claims from within 31 days of the date of the accident and "proof of accident" within 90 days. Claims outside of these time frames will still be evaluated for their timeliness, but must be reported within one year from their required 90 days "proof of accident". Completed claim and disclosure authorization forms can be found online at mybenefits.metlife.com

Claims should be reported as soon as possible by using one of the following methods.

- Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: mybenefits.metlife.com

Mail documents to:
Metropolitan Life Insurance Company
Attn: Hospital Indemnity Insurance Product
P.O. Box 80826 Lincoln, NE 68501-0826

PAYMENT OF BENEFITS

Upon approval of your claim, you will be notified of the benefits paid. If any benefits have been denied, a written explanation will be provided. If you claim is denied, you will receive an explanation of benefits (EOB) or letter with instructions on how to appeal the denial.

Benefits are paid directly to the covered person, unless otherwise agreed upon.

HOW TO APPEAL A DENIED CLAIM

If the claims administrator has denied your claim for Hospital Indemnity benefits, you may appeal the decision. You must file a written appeal within 180 days of the claims administrator's decision. Appeals must be in writing and must include the following information:

- Name of Associate;
- Reference to the initial determination; and
- Reason explaining why you are appealing the initial determination.

Appeals must be sent to the claims administrator at:

You must submit any additional information to the claims administrator when you submit your request for appeal. You may also request that the claims administrator provide you copies of the documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations. Your request must be in writing. Such information will be provided to no cost to you.

The claims administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request, except under special circumstance, the claims administrator may have up to an additional 45 days to provide written notification of the final decision. If the claims administrator needs such an extension, it will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time for the claims administrator to make a final decision is tolled from the date of the extension notice until the plan receives the requested information. You will have 45 days to provide the requested information from the date you receive the notice of insufficiency from the plan. The initial 45 day time period for the claims administrator to make a final written decision, plus the 45 day extension period (if applicable) are tolled from the date the notification of insufficiency is sent to you until the date on which it receives your response or, if earlier, the expiration of 45

days. The tolling period ends when the claims administrator receives your response, regardless of the adequacy of your response.

If the applicable claims administrator denies the claim on appeal, the claims administrator will send you a final written decision that includes the following:

- The specific reason(s) for the appeal decision;
- The pertinent plan provision(s) on which the denial is based;
- If an adverse decision is based on advice of medical or vocational experts, the experts whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- If the claim is denied because the claims administrator did not have sufficient information, an explanation that the claim was denied because of insufficient information, and why such information was needed.
- If an internal rule, protocol, guideline, standard or other criteria was relied upon in making the decision, a statement that such rule, protocol, guideline, standard or other criteria was relied upon and that you may request a copy (if a copy is available) free of charge;
- A statement that the claimant is entitled to receive, upon request and at no cost, copies of documents, records and other information that is relevant to your claim, as determined by the claims administrator under applicable federal regulations;
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency”.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

IMPORTANT NOTE

The Hospital Indemnity Insurance Program is a welfare benefit under ERISA. This section of the Handbook, together with the applicable provisions in the Introduction and Other Information section, are intended to constitute an SPD for the Hospital Indemnity Insurance Program with ERISA.

All benefits and coverage described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.

Company Paid Life Insurance Program

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HOW THE PROGRAM WORKS

Transform provides eligible Associates the Company Paid Life Insurance Program, a component of the Plan (the "Company Paid Life Insurance Program"). There is no cost to the Associate for this coverage, and enrollment is automatic. Part-time hourly Associates are not eligible to participate in the Company Paid Insurance Program.

Please Note: Throughout this section of the Handbook, a few terms are capitalized. These terms are defined under *Some Terms You Should Know*, at the end of this section.

AMOUNT OF COVERAGE

The amount of your coverage is equal to one-times your Eligible Annual Earnings, up to a maximum of $50,000 of coverage. If you are newly hired, your coverage is based on your estimated Eligible Annual Earnings, as determined by Transform any of its subsidiaries or affiliates to which Transform extends participation rights under the Company Paid Life Insurance Program.

Your Eligible Annual Earnings are recalculated annually and the recalculation is effective on July 1, which is the Plan Reclassification Date established by the Plan Administrator. If you are on an approved leave of absence on the date the recalculation is made, a recalculation will not be done for you (if applicable), until the next Plan Reclassification Date when you are not on such a leave of absence.

INCREASES IN EARNINGS

If your earnings have increased since the last time a reclassification calculation was performed on your Eligible Annual Earnings, the increase will be effective on the next Plan Reclassification Date, at which time you will qualify for a higher amount of Company Paid Life Insurance.

If your Eligible Annual Earnings increase is enough to make you eligible for additional coverage, your Company Paid Life Insurance coverage will automatically increase on the next Plan Reclassification Date, provided you are Actively at Work and able to perform normal activities.

DECREASES IN EARNINGS

If your earnings have decreased since the last time a reclassification calculation was performed on your Eligible Annual Earnings, the decrease will be effective on the next Plan Reclassification Date at which time you will qualify for a lesser amount of Company Paid Life Insurance. However, a decrease will only take effect if your Eligible Annual Earnings have qualified you for a lesser amount of Company Paid Life Insurance coverage for two consecutive years.

DESIGNATING A BENEFICIARY

A beneficiary is the person(s) who receives your life insurance death benefit payment if you die while covered by the Plan. You must name a beneficiary for your Life insurance coverage. You can designate your initial beneficiary or change your beneficiary by visiting **www.88sears.com** and clicking the "Health Benefit Center" link in the Benefits section. Once you are logged in, select "Change My Benefits/Basic Info/Change of Beneficiary" and follow the prompts to add or change your beneficiary.

You may name any person(s), any organization or your estate as your beneficiary. If more than one beneficiary is designated, the beneficiaries will share the benefit equally unless you indicate otherwise. When two or more beneficiaries are named and you do not want them to share equally, you must indicate the **percentage** of the benefit each beneficiary is to receive. **Do not specify dollar amounts.**

PROGRAM FEATURES

ACCELERATED BENEFIT OPTION (ABO)

An Accelerated Benefit is an advance (before death) payment of a part or the total amount of an insured's death benefit. To qualify for an Accelerated Benefits, an insured must:

- Be insured for a Plan benefit of at least $10,000;
- Have not assigned your rights under the Plan;
- Not have an irrevocable beneficiary;
- Be terminally ill (expected to die within 24 months); and
- Send proof of terminal illness to MetLife that the insured's life expectancy is 24 months or less. This must include a completed accelerated benefit claim form, and signed certification by a physician. MetLife retains the right to have you medically examined at MetLife's expense to verify the insured's medical condition.

An Accelerated Benefit is not available if the insured is:

- Required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- Required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

If an insured qualifies, MetLife will allow a full or a partial Accelerated Benefit.

- A full Accelerated Benefit will pay up to 100% of the insured's amount of insurance (basic company-paid and optional insurance combined up to a maximum of $1,000,000);

If a partial Accelerated Benefit is chosen, the insured's remaining death benefit will remain in force. The remaining amount of insurance will be the full amount of insurance minus the amount of insurance that was accelerated. If a full Accelerated Benefit is chosen, the insured's coverage will cease.

Benefits received under this Accelerated Benefits provision may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death.

CONVERSION OPTION

You are eligible to convert or port your Company Paid Life Insurance to an individual policy at the time of termination of coverage. You will receive information about converting your Company Paid Life Insurance shortly after your coverage ends. You may elect to convert your coverage within 31 days of your termination of employment. The 31 day period allowed for conversion and portability begins on the first day after coverage has terminated.

PORTABILITY OPTION

If you leave Transform or retire, you may be able to take your Associate Basic Life, Optional Life, Spouse Optional Life and/or Child Life Insurance with you and continue to pay group term life rates directly to MetLife. Rates may be higher than you paid as an active Associate. If you elect to continue your own insurance, you can also continue insurance on your spouse and/or children.

The minimum amount of insurance that can be continued on an Associate's life under the portability option is $10,000. The minimum for dependents life is $10,000 for a spouse partner on a stand-alone basis, or $2,500 if porting with the Associate. The minimum is $1,000 for a child.

Associate

The maximum amount of insurance that can be continued under this rider is based on the amount of insurance that was in force on the insured's portability date, but not greater than $2,000,000 for the Associate.

Spouse

The maximum amount of insurance that can be continued under this rider is based on the amount of insurance that was in force on the insured's portability date, but not greater than $250,000 for the Spouse, or $25,000 for children.

An Associate or Spouse can apply for preferred rates, and higher benefit amounts by satisfactorily answering medical questions. Claims Information

The following information will help you to better understand the claim review and appeal process with respect to Company Paid Life Insurance.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Company Paid Life Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Company Paid Life Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the

Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

If You Have a Benefit Claim

These procedures apply to claims for benefits relating to Company Paid Life Insurance coverage. Contact the Transform Benefits Department **BenefitsDepartment@transformco.com** to report a life insurance claim. A claim kit will be sent to your beneficiary, or, if applicable, to your home address on file. The claim form must be completed and returned to the Claims Administrator at:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505

Payment of Benefits

Upon approval of your claim, your beneficiary will be notified of the benefits paid. If any benefits have been denied, a written explanation will be provided, including appeal procedures. If you do not have a beneficiary on file, death benefits will be paid in the following order:

- Your lawful spouse if living; otherwise
- Your natural or legally adopted child (children) in equal shares, if living; otherwise
- Your parents in equal shares, if living; otherwise
- Your natural or legally adopted siblings in equal shares, if living; otherwise
- Your estate.

Death benefits will be paid in a single sum, or by any other method agreeable to MetLife and the beneficiary.

How To Appeal A Denied Claim For Benefits

If the claims administrator denies your life insurance claim in whole or in part, you or, if applicable, your beneficiary can request a review of your claim. This request for review should be sent to the applicable claims administrator at:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505

The appeal must be filed within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

The claims administrator will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

Assignment

The rights and benefits under the Plan are not assignable prior to a claim for benefits, except as required by law. The Plan is not responsible for the validity of an assignment.

Some Terms You Should Know

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer requires you to travel.

If you are not actively working due to illness or injury you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

ELIGIBLE EARNINGS

Hourly Associates: Prior payroll year earnings, as determined by practices established by Transform (or if you are newly hired, your estimated annual earnings, as determined by Transform), rounded to the nearest higher $1,000. If your earnings are an even multiple of $1,000 then no rounding will occur.

Salaried Associates: are 120% of your base pay, as determined by Transform established personnel practices. *Exception:* For certain Transform Home Improvement Products Associates and Transform Commercial Sales Associates who are paid on a salary plus bonus basis, Eligible Annual Earnings are your prior payroll year earnings, as determined by Transform established personnel practices (or if you are newly hired, your estimated annual earnings, as determined by Transform), rounded to the nearest higher $1,000. If your earnings are an even multiple of $1,000, then no rounding will occur.

Plan Reclassification Date is the annual date set by the Plan Administrator to determine increases or decreases in Earnings for the purposes of deciding future amounts of Company Paid Life Insurance. The Plan Reclassification Date is July 1 of each year, unless it is changed prospectively by the Plan Administrator.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits.
- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers.

IMPORTANT NOTE

Company Paid Life Insurance is a welfare benefit plan under ERISA. This section of the Handbook, together with the applicable provisions of the *Introduction* and *Other Information* sections, are intended to constitute an SPD in accordance with ERISA. All benefits and coverages described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.

Optional Life Insurance Program

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HOW THE PROGRAM WORKS

Transform recognizes Associates' desire to protect their family's financial future. That's why Transform and its participating affiliates offer you the Optional Life Insurance Program underwritten by Metropolitan Life Insurance (MetLife), a component of the Plan (the "Optional Life Insurance Program"). The Optional Life Insurance Program provides flexibility in meeting the specific needs of your family. You can increase your Optional Life Insurance Coverage as your income grows (subject to maximum limits and evidence of insurability requirements), expand benefits to include new family members, or reduce coverage as your family matures and you are near retirement.

Please Note: Throughout this section of the Handbook, several terms are capitalized. These terms are defined under *Some Terms You Should Know*, at the end of this section.

CHOOSE THE COVERAGE THAT MEETS YOUR NEEDS

You can choose to cover yourself for 1, 2, 3, 4, 5, 6, 7 or 8 times your Eligible Earnings up to a maximum of $4,000,000.

You can also elect coverage for your spouse and children. Coverage amounts can be adjusted as your life insurance needs change, within the program guidelines.

ASSOCIATE COVERAGE

You may elect a coverage amount of up to eight times your Eligible Earnings (rounded to the nearest higher $1,000) up to a maximum of $4,000,000. Some levels of coverage may require evidence of insurability. Please refer to the following guidelines for electing Associate coverage:

Coverage Amount	Requirements for Electing Coverage Amount
Multiples of Eligible Earnings: ▪ 1 times ▪ 2 times ▪ 3 times Or $500,000 (whichever is less)	Requires: ▪ Meeting eligibility requirements ▪ Evidence of insurability if enrolling after 31 days of initial eligibility
Multiples of Eligible Earnings: ▪ 4 times ▪ 5 times ▪ 6 times ▪ 7 times ▪ 8 times or amounts in excess of $500,000 in coverage	Requires: ▪ Meeting eligibility requirements ▪ Evidence of insurability ▪ Medical underwriting approval before coverage can be issued

If evidence of insurability is required, you will need to provide proof of good health satisfactory to the insurance company before coverage becomes effective. Coverage that is subject to the evidence of insurability requirement will not take effect until the evidence is approved by the insurance company.

SPOUSE COVERAGE

Spouse coverage is available in $10,000 increments up to a maximum of $250,000. You are not required to participate in Associate coverage under the Optional Life Insurance Program in order to elect coverage for your spouse. However, spouse coverage cannot exceed the sum of your Optional Life coverage and the Company Paid Life Insurance Coverage. You can enroll your spouse for up to $20,000 of insurance without proof of good health if application is made within 31 days of the spouse's initial eligibility. Coverage amounts of greater than $20,000 made during a period of initial eligibility, or any election made outside a period of initial eligibility require evidence of insurability. Please refer to the following guidelines for electing spouse Optional Life Insurance coverage:

Coverage Amount	Requirements for Electing Coverage Amount
$20,000 spouse coverage cannot exceed Associate coverage (Company Paid plus Optional Life)	Requires: ▪ Meeting eligibility requirements ▪ Evidence of insurability not required for elections of up to $20,000 if made within 31 days of the spouse's date of initial eligibility. ▪ Evidence of insurability is required for all coverage amounts elected outside a period of initial eligibility.
$30,000 to $250,000 (in $10,000 increments); provided that spouse coverage cannot exceed sum of Associate coverages (Company Paid plus Optional Life)	Requires: ▪ Meeting eligibility requirements ▪ Evidence of insurability ▪ Medical underwriting approval before coverage can be issued

If evidence of insurability is required, your spouse will need to provide proof of good health satisfactory to the insurance company before coverage becomes effective. If your spouse or child is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, the effective date of coverage will be

delayed until he or she is released from such hospitalization or confinement (does not apply to a newborn child).

CHILD COVERAGE

Child coverage is available in $5,000 increments up to a maximum of $25,000 for each eligible dependent child at one low premium for all children in the family. You are not required to elect Associate coverage under the Optional Life Insurance Program in order for dependent children to be eligible for child coverage. Eligible dependent children include you or your spouse's natural, legally adopted or stepchildren, and foster children who are less than 26 years old. An adopted child includes a child legally placed with you for adoption. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26, and are financially dependent on you for more than one-half of their support and maintenance.

Coverage Amount	Requirements for Electing Coverage Amount
Flat benefit options: ▪ $5,000 ▪ $10,000 ▪ $15,000 ▪ $20,000 ▪ $25,000 The option you select applies to each eligible child	Coverage is guaranteed

OTHER PROGRAM FEATURES

SUICIDE PROVISION

If you or your insured dependent commit suicide within two years from the effective date of any contributory life insurance, optional life benefits will not be payable.

Instead, the beneficiary will receive an amount equal to any contributions paid, without interest.

- In addition, if there has been an increase in the amount of your optional life insurance, or that of your insured dependent for which the insured was required to apply or for which we required evidence of insurability, and the insured commits suicide within two years of the effective date of the increase in coverage, the suicide exclusion of the policy will apply to the increase in coverage. The insurance company's liability with respect to that increase will be limited to the premiums paid and attributable to such increase. the increased

ACCELERATED BENEFIT OPTION (ABO)

An Accelerated Benefit is an advance (before death) payment of a part or the total amount of an insured's death benefit. To qualify for an Accelerated Benefits, an insured must:

- Be insured for a Plan benefit of at least $10,000;
- Have not assigned your rights under the Plan;
- Not have an irrevocable beneficiary;
- Be terminally ill (expected to die within 24 months); and
- Send proof of terminal illness to MetLife that the insured's life expectancy is 24 months or less. This must include a completed accelerated benefit claim form, and a signed certification by a physician. MetLife retains the right to have you medically examined at MetLife's expense to verify the insured's medical condition.

An Accelerated Benefit is not available if the insured is:

- Required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- Required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

If an insured qualifies, MetLife will allow a full or a partial Accelerated Benefit.

If a partial Accelerated Benefit is chosen, the insured's remaining death benefit will remain in force. The remaining amount of insurance will be the full amount of insurance minus the amount of insurance that was accelerated. If a full Accelerated Benefit is chosen, the insured's coverage will cease.

Benefits received under this Accelerated Benefits provision may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

The Accidental Death and Dismemberment (AD&D) option is designed to provide financial protection for you or your beneficiary if you or a covered family member dies or is seriously injured in a Covered Accident. If elected by you, the amount of AD&D insurance will equal the amount of optional life insurance.

AD&D FEATURES

For the Loss of	Percentage of AD&D Benefit Payable
Life as a result of an accident	100%
Loss of any combination of hand/foot and or eye	100%
Loss of one hand or foot	50%
Thumb and index finger on same hand	25%
Sight of an eye	50%

For the Loss of	Percentage of AD&D Benefit Payable
Hearing in both ears	50%
Speech	50%
Hearing in both ears and speech	100%
Loss of Arm or leg	75%
All four fingers of one hand	50%
All toes on one foot	25%
Big toe only	13%
Coma	1% per month, up to 100 months

Covered Losses Also Include	Percentage of AD&D Benefit Payable
Total paralysis of both upper and lower limbs (quadriplegia)	200%
Total paralysis of both lower limbs (paraplegia)	75%
Total paralysis of upper and lower limbs on one side of the body (hemiplegia)	50%
Total paralysis of one arm or leg	25%

OTHER BENEFITS

- Seat Belt Benefit: Additional benefit for loss of life as a result of a covered accident while driving or riding in a private passenger car while using a seatbelt. The benefit is an amount equal to the lesser of 10% of the amount of AD&D insurance on the person or $25,000, but not less than $1,000.
- Day Care Benefits: 10% to $10,000 up to four (4) years
- Child Education Benefit: 10% to $25,000 up to four (4) years
- Spouse Education Benefit: 5% to $10,000 up to four (4) years subject to enrollment within 12 months of date of loss
- Common Disaster Benefit: If you and your insured spouse die in a common accident, the amount of spouse AD&D insurance will be increased to an amount equal to 100% of your amount of AD&D insurance, but not more than $250,000.
- If an insured's body is not found within a year from the date of disappearance, it will be presumed the insured has died and the death will be considered an accidental death
- Exposure to the elements will be considered an accidental bodily injury.
- Air Bag Benefit: Additional benefit for loss of life as a result of a covered accident while driving or riding in a private passenger car while using an air bag. The benefit is an amount equal to the lesser of 10% of the amount of AD&D insurance on the person or $25,000, but not less than $1,000.
- Child Loss: If an insured dependent child suffers a covered loss, other than loss of life, the amount payable shall be twice the amount payable under the AD&D benefit, subject to a maximum of $50,000.
- Home/Vehicle Alteration Benefit: 10% to $10,000. Home/Vehicle Alteration Benefit applies if the insured suffers a Loss that requires home alteration or vehicle modification.
- Medical Premium Benefits: If you die as a result of a covered accident and are survived by a spouse and/or one or more dependent children, we will pay an additional benefit to allow your surviving spouse and/or children to continue their group medical coverage. The benefit will be paid annually and will be equal to the lesser of (1) 1% of your amount of AD&D insurance; or (2) $3,000. Payment will be made when proof is provided to MetLife that group medical insurance premiums have been paid.
- Surviving Spouse Benefit: Benefit pays an additional amount in installments for Associates or Spouses who die as a result of an accidental injury, providing that one spouse survives the other by at least a 48 hour period. Benefit amount is 1% of the full amount for 12 months following the date of death.

WHEN AD&D BENEFITS ARE NOT PAYABLE

An insured's loss, death or dismemberment must occur within 365 days after the date of the accidental injury. In no event will a benefit be payable where the insured's accident, injury, loss, death or dismemberment is caused directly from, any of the following:

- self-inflicted injury or self-destruction, whether sane or insane; or
- suicide or attempted suicide, whether sane or insane; or
- the insured's participation in, or attempt to commit assault or felony regardless of any legal proceedings thereto; or
- bodily or mental infirmity, illness or disease; or
- the insured's being legally intoxicated, as defined and determined by the laws of the state where the injury or loss occurred; or
- the use of prescription drugs, non-prescription drugs, medications (unless administered on the advice of a physician and taken in the verifiably prescribed manner and dosage).This does not include involuntary or unintentional ingestion of non-prescription drugs or medications taken per label instructions; or

- the voluntary use of illegal drugs; or
- poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poison; or
- motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
- infection, other than infection occurring simultaneously with, and as a direct result of, the accidental injury; or
- medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - travel in an aircraft or device used:
  - for testing or experimental purposes;
  - by or for any military authority; or
  - for travel or designed for travel beyond the earth's atmosphere
- war or any act of war, whether declared or undeclared. Terrorism is not considered an act of war.

COST FOR COVERAGE

You monthly premium for coverage depends on age, coverage level and whether you do/do not smoke. ***Note****:* Your premium for Optional Life (including spouse coverage) is based on your age as of December 31 of the current plan year.

COVERAGE CHANGES

Coverage amounts can be adjusted as your life insurance needs change, within program guidelines. You may apply for new coverage as a Late Entrant or for additional coverage at any time. However, coverage may be subject to proof of good health. before coverage can be issued. The Associate must also be Actively at Work and the dependent spouse also must not be home or hospital confined for medical care or treatment in order for the increase to be effective.

INCREASES IN ELIGIBLE EARNINGS

If your earnings have increased since the last time a reclassification calculation was performed on your Eligible Earnings, the increase will be effective on the next Plan Reclassification Date at which time you will qualify for a higher amount of Optional Life Insurance.

If your Eligible Earnings increase enough to make you eligible for additional coverage, your Optional Life Insurance Coverage and corresponding payroll deduction will automatically increase on the next Plan Reclassification Date, provided you are Actively at Work and able to Perform Normal Activities.

HOW TO CANCEL COVERAGE

You may cancel your coverage at any time. For further information contact the Transform Benefits Center at **1-888-887-7327, option 1**.

DESIGNATING A BENEFICIARY

A beneficiary is the person(s) who receives the life insurance and AD&D benefit if the covered individual dies while covered by the Plan. You must name a beneficiary for your Optional Life insurance and AD&D benefit coverage. You can designate your initial beneficiary or change your beneficiary by visiting **www.88sears.com** and clicking the "Health Benefits Center" link in the Benefits section. Once you are logged in, select "Change My Benefits/Basic Info/Change of Beneficiary" and follow the prompts to add or change your beneficiary.

You may name any person(s), any organization or your estate as your beneficiary. If more than one beneficiary is designated, the beneficiaries will share the benefit equally unless you indicate otherwise. When two or more beneficiaries are named and you do not want them to share equally, you must indicate the **percentage** of the benefit each beneficiary is to receive. **Do not specify dollar amounts.**

You are automatically the beneficiary for any coverage your spouse and child(ren) have under the Plan.

CONTINUING YOUR COVERAGE

Upon termination of employment, you will receive information about continuing your insurance coverage directly from MetLife. You may elect to "port" or "convert" your coverage within 31 days of your termination. The 31 day period allowed for conversion and portability begins on the first day after coverage has terminated.

PORTABILITY OPTION

If you leave Transform or retire, you may be able to take your Associate Optional Life, Spouse Life and/or Child Life Insurance with you and continue to pay group term life rates directly to MetLife. Rates may be higher than you paid as an active Associate. If you elect to continue your own insurance, you can also continue insurance on your spouse and/or children.

The minimum amount of insurance that can be continued on an Associate's life under the portability option is

$10,000. The minimum for dependents life is $10,000 for a spouse partner on a stand-alone basis, or $2,500 if porting with the Associate. The minimum is $1,000 for a child.

Associate

The maximum amount of insurance that can be continued under this rider is based on the amount of insurance that was in force on the insured's portability date, but not greater than $2,000,000 for the Associate.

Spouse and Child

The maximum amount of insurance that can be continued under this rider is based on the amount of insurance that was in force on the insured's portability date, but not greater than $250,000 for the Spouse, or $25,000 for Child.

An Associate or Spouse can apply for preferred rates, and higher benefit amounts by satisfactorily answering medical questions.

Ported AD&D insurance is available without life insurance.

CONVERSION OPTION

You are eligible to convert coverage under the Plan to an individual policy, an amount which represents the difference between the amount of your coverage at the time coverage terminates and the amount you elect to continue through the portability option. Covered dependents may also convert their full amount of coverage to an individual policy.

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the Optional Life Insurance Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Optional Life Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Optional Life Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at the following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A BENEFIT CLAIM

These procedures apply to claims for benefits relating to Optional Life Insurance coverage. To report a claim, contact the Transform Benefits Center through **1-888-887-3277**. A claim kit will be sent to you, if applicable, or, your beneficiary. The claim form must be completed and returned to the Claims Administrator at:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505

PAYMENT OF BENEFITS

Upon approval of your claim, you (or your beneficiary) will be notified of the benefits to be paid. If any benefits have been denied, a written explanation will be provided including appeal procedures. If you do not have a beneficiary on file, benefits will be paid in the following order:

- your lawful spouse, if living; otherwise
- your natural or legally adopted child (children) in equal shares, if living; otherwise
- your parents in equal shares, if living; otherwise
- your natural or legally adopted siblings in equal shares, if living; otherwise;
- your estate.

For dependent coverage, benefits will be paid to you if living, otherwise to your estate.

Death benefits will be paid in a single sum, or by any other method agreeable to MetLife and the beneficiary.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If the claims administrator denies your life insurance claim in whole or in part, you or, if applicable, your beneficiary can request a review of your claim. This request for review should be sent to the applicable claims administrator at:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505

The appeal must be filed within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

The claims administrator will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

ASSIGNMENT

The rights and benefits under the Plan are not assignable prior to a claim for benefits, except as required by law. The Plan is not responsible for the validity of an assignment.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the Other Information section of this Handbook:

- When you can make changes to your benefits
- Coverage continuation for certain benefits
- Contact information for benefit claims administrators and insurance carriers

SOME TERMS YOU SHOULD KNOW

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer requires you to travel.

If you are not actively working due to illness or injury you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

Covered Accident means an accident as defined in the Accidental Death and Dismemberment Certificate Supplement attached to your Certificate of Insurance.

Eligible Earnings

Hourly Associates: Prior payroll year earnings, as determined by practices established by Transform (or if you are newly hired, your estimated annual earnings, as determined by Transform), rounded to the nearest higher $1,000. If your earnings are an even multiple of $1,000 then no rounding will occur.

Salaried Associates: are 120% of your base pay, as determined by Transform established personnel practices. *Exception:* For certain Transform Home Improvement Products Associates and Transform Commercial Sales Associates who are paid on a salary plus bonus basis, Eligible Annual Earnings are your prior payroll year earnings, as determined by Transform established personnel practices (or if you are newly hired, your estimated annual earnings, as determined by Transform), rounded to the nearest higher $1,000. If your earnings are an even multiple of $1,000, then no rounding will occur.

Late Entrant is an applicant enrolling in the Optional Life Insurance Program after the 31 day initial eligibility enrollment period has passed.

Life Insurance Coverage is the stated amount of life insurance benefit provided on the Associate's life or the life of the Associate's spouse or child(ren).

Plan Reclassification Date is the annual date set by the Plan Administrator to determine increases in Earnings for the purposes of deciding future amounts of Optional Life Insurance. The Plan Reclassification Date is July 1 of each year, unless it is changed prospectively by the Plan Administrator.

IMPORTANT NOTE

The Optional Life Insurance Program is a welfare benefit plan under ERISA. This section of the Handbook, together with the applicable provisions in the *Introduction* and *Other Information* sections, are intended to constitute an SPD for the Optional Life Insurance Program in accordance with ERISA.

All benefits and coverage described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.

Business Travel Insurance Program

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HOW THE PROGRAM WORKS

Transform provides Business Travel Insurance to eligible Associates at no cost to the Associate, and regardless of length of service. The Business Travel Insurance Program component of the Plan (the "BTI Program") provides 24-hour insurance that pays for accidental death or dismemberment from injuries caused by an accident while traveling on Transform business.

The BTI Program covers accidents in which death or dismemberment results (within 365 days of the accident) from injury caused by the accident while the Associate is traveling on Transform business. This includes hotel fires and other accidents incidental to Transform business.

For purposes of the BTI Program, *injury* means accidental bodily injury resulting independently of sickness and all other causes. Any Associate, while on an authorized business trip away from the premises of his or her regular place of employment is considered to be traveling on company business. For service technicians, business travel occurs when an Associate is traveling outside his or her city of permanent assignment.

Such trips begin when you leave your home or place of employment, whichever occurs last. A trip ends when you return to your home or place of employment, whichever occurs first.

WHAT IS COVERED

When traveling on company business, you are covered while:

- A passenger in, boarding or alighting from any Transform-owned aircraft;
- A passenger in, boarding or alighting from a commercial aircraft, or any public conveyance licensed to carry passengers for hire (common carriers);
- A passenger in, boarding or alighting from any non-scheduled, private aircraft used for pleasure purposes with no commercial intent during flight or as a passenger in military aircraft flown by the Air Mobility Command or its foreign equivalent;
- A passenger in, boarding or alighting from a chartered multi-engine aircraft;
- An authorized Transform pilot or Transform crew member;
- Driving a car, or as a passenger in someone else's car; and
- During the course of any trip, including a sojourn or personal deviation taken during the course of the trip

WHAT IS NOT COVERED

Aircraft travel other than that listed above is not covered. Injury or death caused by suicide, attempted suicide, or intentionally self-inflicted injury or acts of declared or undeclared war within the U.S. (including its territories or possessions) or your country of citizenship or permanent residence.

Driving to and from work, travel for any vacation or holiday or travel while on leave of absence is not covered.

In no event is coverage provided for a flight that includes crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any forms of hunting, bird or fowl herding, banner towing, or any test or experimental purpose.

Other exclusions include:

- Sickness, disease, or mental infirmity;
- Viral or bacterial infection or medical, surgical treatment related to the infection;
- Exposure to viral, bacterial or chemical agents except for infection from an external cut or accidental ingestion of contaminated food; and
- Accidents while engaged in military active duty or reserve or National Guard training extending beyond 31 days.

COVERAGE AMOUNT

IF YOU DIE

The amount of your insurance coverage for death from other than common carrier accidents is two times your Annual Salary (as defined below), up to a Principal Sum of $500,000 (subject to the age restrictions below).

The Principal Sum is $500,000 for an Associate's death while traveling in a common carrier such as a taxi cab or train or any airplane in which you are traveling as a fare-paying passenger. When riding in a Transform-owned or operated aircraft, your Principal Sum remains at two times your Annual Salary, up to $500,000.

The maximum limit of liability for covered losses for all persons that may result from any one accident is $15 million. (The claims adjustor decides the actual amount paid.)

IF YOU ARE INJURED

Where the injuries are not fatal; but within 365 days of the accident that caused the loss of:

- two limbs (such as two hands, two feet or a hand and a foot – or the sight in both eyes, or a combination of a hand or foot and sight of one eye) or the loss of speech and hearing in both ears, you will receive 100% of the Principal Sum as described above.
- one limb or the sight in one eye, or loss of hearing in both ears, you will be paid 50% of the amount of the Principal Sum.
- the thumb and index finger on the same hand, you will be paid 25% of the Principal Sum.

If as a result of a covered accident you experience Paralysis determined by the Physician to be permanent, the following benefits will be payable:

- 25% of the Principal Sum is payable for Paralysis in one limb.
- 50% of the Principal Sum is payable for Paralysis of the upper and lower limbs on the same side of the body.
- 75 % of the Principal Sum is payable for Paralysis in the two upper or the two lower limbs.
- 100% of the Principal Sum is payable for Paralysis in all four limbs.

If you lapse into an irreversible Coma within 90 days of the accident that caused the injury as a result of a covered accident and the Coma continues for 30 consecutive days, the BTI Program will pay 1% of the Principal Sum per month. The benefits ceases on the earliest of: (1) the date the insured person ceases to be comatose due to that injury; (2) the date the insured person dies; or (3) the date of the total amount of the monthly Coma benefits paid for all injuries caused by the accident equals 100% of the Principal Sum.

OTHER BENEFIT FEATURES

Seatbelts and Airbags: If you are wearing a seat belt in a private passenger automobile during a covered accident resulting in your loss of life, an additional 10% of the Principal Sum up to a maximum of $50,000 is payable.

If the vehicle is equipped with an air bag during a covered accident resulting in your loss of life, an additional 10% of the Principal Sum up to a maximum of $50,000 is payable. If it is unclear if the person was wearing a seat belt or was positioned in a seat with a properly functioning and properly deployed airbag, $1,000 will be paid.

Exposures and Disappearances: A loss due to accidental exposure to the elements is covered as an injury under this BTI Program. Loss of life is presumed after one year following the disappearance of the insured.

Bereavement and Trauma Counseling: If you or your immediate family member requires bereavement and trauma counseling because of a covered loss, a benefit of $150 per session up to 10 sessions will be paid if the counseling expenses are incurred within one year of the date of the covered accident.

Home Alteration and Vehicle Modification: If you suffer a covered dismemberment or Paralysis during a covered business trip or if your spouse or dependents suffer a covered dismemberment or Paralysis while on a covered business or relocation trip, an additional benefit of up to $25,000 will be provided for modifying your home or vehicle as long as the adaptive services are required within one year of the date of the covered accident.

Accident Medical Expense Benefit: If an insured person suffers an injury that within 90 days of the date of the accident that caused the injury, requires him or her to be treated by a Physician, Transform will pay the usual and customary charges incurred for covered medical services received due to that Injury up to $250,000 per insured person for all Injuries caused by the same accident. This benefit is payable for such charges incurred after the deductible of $100 has been met and within 52 weeks after the date of accident causing that injury.

Rehabilitation Benefit: A benefit of up to a maximum of $50,000 will be paid if you or your covered dependents require rehabilitation within two years of the date of the covered loss as determined necessary by a Physician.

Felonious Assault: In the event you suffer a covered loss resulting from attempted robbery or holdup, kidnapping or attempted kidnapping, or other felony assault that takes place on the premises of your place of permanent assignment, a benefit of two times your Annual Salary up to a maximum of $500,000 will be provided. However this benefit does not apply, if the insured person commissions or attempts to commit a felony.

TO WHOM THE BENEFIT IS PAID

All covered injuries, other than loss of life will be payable to you. In the event of a covered loss of life, the Principal Sum is payable to the person designated under the Company Paid Life Insurance Plan. If there is no such designation, then the benefit is payable to your spouse. If there is no spouse, the benefit is payable to your children, if there are no children, then to your parents, and if there are no living parents, then to your siblings, and if there are no siblings, then to your estate.

COVERAGE EXTENSION FOR SPOUSES AND DEPENDENT CHILDREN

Spouses and dependent children (enrolled full-time students up to age 19 or age 25 and primarily supported by you) are covered during a relocation or business trip for which Transform pays part or all of the cost. The definition of a dependent child is an unmarried child who is one of the following:

- A child from birth date to 19 years of age;
- A child who is age 19 or more but less than age 25, enrolled in school as a full-time student and primarily supported by the covered person; or
- A child who is age 19 or more who is incapable of self-sustaining employment by reason of mental or physical handicap and is primarily supported by the covered person.

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the BTI Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you

are not eligible for coverage under the BTI Program, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

The Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at following address or fax number:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

The Plan Administrator will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Plan Administrator receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Plan Administrator at the address listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Plan Administrator receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A CLAIM FOR BENEFITS

Forms for filing a claim for benefits under the BTI Program can be obtained from:

Transform Midco LLC
Risk Management Department
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192

The claims administrator will notify you in writing of its initial claims decision. Such notification will be provided within a reasonable period, not to exceed 90 days after receipt of the claim, unless the claims administrator determines that an extension is necessary (up to an additional 90 days).

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

If the claims administrator denies your claim under the BTI Program in whole or in part, you or, if applicable, your beneficiary can request a review of your claim. This request for review should be sent to the claims administrator at:

AIG
Claims Administration
PO Box 25987
Shawnee Mission, KS 66225

The appeal must be filed within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

Your claim will be re-evaluated and you or, if applicable, your beneficiary will be informed of the decision within 60 days, subject to an additional 60-day extension. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based.

You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you or your beneficiary are not satisfied with the results of the appeal decision, you may file a second appeal within 31 days of the first appeal denial. Enclose copies of pertinent information, statements or rejection letters, and an explanation of the basis for the second appeal. Be sure to keep copies of all materials for your records.

Your appeal will be re-evaluated and you or, if applicable, your beneficiary will be informed of the decision within 60 days, subject to an additional 60-day extension. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

Claim Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- For an initial claim, a description of the appeal procedures; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim upon review.

The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you have the right to bring a civil action under Section 502(a) of ERISA, provided that you bring such action within 6 months of receiving an adverse benefit determination of your second level appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

TRAVEL ASSISTANCE SERVICES

When traveling you have access to information 24 hours a day including:

Travel Medical Assistance (including)

- Emergency medical evacuation transportation assistance
- Physician / hospital referrals

Worldwide Travel Assistance (including)

- Lost baggage search; stolen luggage assistance
- Lost passport / travel documents
- Inoculation information
- Embassy or Consulate Referral

Emergency Travel Assistance (including)

- Emergency return travel arrangements

Concierge Services (including)

- Group transportation coordination
- Wireless device assistance

Personal Security (including)

- Security Evacuation
- Security and safety advisories

Identity Theft Services

In addition, if you or your dependents that may be traveling with you suffer a medical emergency and a physician designated by Ambassador Travel in consultation with a local attending physician determines that it is medically necessary to be transported under medical supervision, Ambassador Travel will arrange and pay for the evacuation.

Contact Ambassador Travel Assistance at **1-877-244-6871** (U.S. and Canada) or Overseas at **+1-713-260-5592** to speak to a personal assistant. When contacting Ambassador Travel Assistance, please indicate that you are an Associate of Transform Midco LLC covered under policy # GTP 0009129594.

SOME TERMS YOU SHOULD KNOW

Annual Salary: Your Annual Salary is the total compensation you received from Transform during the 12-month period immediately prior to the covered accident. If you have less than 12 months' earnings, your Annual Salary amount is computed by extending for a 12-month period the average compensation that you received before the loss.

Coma: A profound state of unconsciousness from which it is unlikely to recover through powerful stimulation, as determined by a Physician. The Coma must begin within 90 days of the accident and continue for 30 consecutive days.

Paralysis: The total loss of use as determined by a Physician to be complete and irreversible.

Physician: A U.S. licensed health care provider practicing in the United States within the scope of his/her license and rendering care and treatment to the covered person that is appropriate for the condition and locality and who is not the covered person, a parent, sibling, spouse or child of the covered person; a person living in the covered person's household; a person employed or

retained by the policyholder; or a person providing homeopathic, aroma-therapeutic or herbal-therapeutic services.

Principal Sum: The amount of your insurance coverage for accidental death. Principal Sum is also used in the determination of the percentage of payout for accidental dismemberment and paralysis benefits.

Principal Sum Age Reductions:

100% of Principal Sum ages 70-74
65% of Principal Sum ages 75-79
30% of Principal Sum age 80-84
15% of Principal Sum age 85 and over

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this Handbook:

- Coverage continuation for certain benefits; and
- Contact information for benefit claims administrators and insurance carriers.

IMPORTANT NOTE

The Business Travel Insurance Program is a welfare benefit plan under ERISA. This section of the Handbook, together with the applicable provisions of the *Introduction* and *Other Information* sections are intended to constitute an SPD in accordance with ERISA.

WorkLife Solutions

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HOW THE PROGRAM WORKS

WorkLife Solutions is an Associate assistance program ("EAP") that provides resources and referral services designed to help you better manage the demands of both your career and your family. Part-time hourly Associates are eligible to participate in the WorkLife Solutions program after completing one year of service with the Company.

OVERVIEW

Whenever you need information or assistance to resolve a personal or family issue, a trained consultant is available to assess your situation and provide consultation and counseling services if requested and propose appropriate resources to help you address the particular issue.

Generally, the EAP works as follows:

- You call WorkLife Solutions at **1-800-424-4732** and consultants are available to assist you with a wide variety of resource and referral services or personal issues as well as in the moment counseling services 24 hours a day, seven days a week.
- Most conversations only take about 15 minutes. In some cases, the consultant can assist you right away in developing an action plan to address your concerns. You can speak with a counselor over the phone, in person or via televideo for a full counseling session. A full session typically runs about 50 minutes. If you wish to speak with a counselor for an in-person session, the consultant will assist you with identifying appropriate providers in your community for your need. It is important to contact WorkLife Solutions once you choose the provider you wish to see to obtain an authorization number. Packets of educational materials related to your concerns can also be sent to you immediately.
- If you need a referral for resources, such as a referral for childcare, school options or senior care including housing, the consultant will listen to your needs to address your concerns. Using the information you provide, the consultant will conduct a search for appropriate providers in your area, and screen them via phone interviews based on your needs. Once the search is complete, you will receive customized, qualified referrals and educational materials such as informational packs and books. Consultants follow up with every caller to ensure that the information received has met their needs.

RESOURCE AND REFERRAL SERVICES

Wherever you are in life—new to parenthood, raising school-aged children or on the verge of retirement—it is very likely that at some point you or a family member may need to make decisions about day care, elder care, college or other special needs. Sorting through the options can be very time consuming. WorkLife Solutions is intended to save you time and help you make informed decisions.

Becoming a Parent

As most parents already know, and as new parents will soon discover, there will always be new challenges in the art of being a parent. Here are a few areas in which you can receive information and referrals:

- Preparing for pregnancy;
- Adoption;
- The essentials of good parenting;
- Parenting – from toddlers to teens; and
- Keeping kids safe and healthy.

Child Care

Choosing an appropriate day care provider is one of the most important decisions a parent can make. WorkLife Solutions consultants can help you sort through the many options and issues associated with child care, including:

- Family home providers, day care centers, nannies and/or au pairs;
- Emergency and sick care; and
- Knowing state licensing requirements.

Special Needs

Get help for you and your special needs child, including:

- Testing and assessment;
- Intervention programs;
- Supportive resources for handling disabilities; and
- Community resources for dealing with attention disorders.

Emergency Care Services

Sometimes a situation needs immediate attention, but you're not sure where to go for help with care needs. The program can help you identify resources such as:

- Nanny and back-up child care services;
- Home health agencies; and
- Community resources.

School and College Decisions

WorkLife Solutions can help you with topics such as:

- School options, camps and special programs;
- Financial aid and scholarships; and
- Admissions and standardized test preparations.

Mature Transitions

WorkLife Solutions can also help you with mature transition topics such as:

- Lifestyle changes;
- Health and wellness issues; and
- Volunteer opportunities.

Elder Care

WorkLife Solutions consultants understand the issues surrounding elder care. Here are some of the ways they can help:

- Senior housing options;
- Adult day care; and
- Home Health Care.

ASSOCIATE ASSISTANCE

WorkLife Solutions consultants are also available to provide access to personal consultation 24 hours a day, seven days a week. Use of the personal consultation services is voluntary, but Transform encourages Associates and/or other eligible family members with personal problems to take advantage of this service.

Consultants are trained to offer assistance on any number of issues you might face, whether they are related to work, family, relationships, grief, finance, anxiety or depression, substance abuse, or other personal issues including assistance with chronic medical conditions, quality of life concerns, and in working to achieve better work/life balance.

When you need to speak to a consultant, call the toll free number **1-800-424-4732**. Telephonic counseling and televideo services are available at any time, 24 hours, and 7 days a week. Such services are provided by master's level counselors. If you would like to meet with a counselor in person, you will be referred to an Associate assistance counselor in your community to receive up to three counseling sessions per issue. The consultant can also assist you with referrals to behavioral health treatment available through your medical program, when applicable. You will be responsible for the costs of any such treatment. You may also be referred to an Associate assistance counselor for an assessment and in-person counseling or treatment if you violate the Transform Drug-Free Workplace Policy or if it appears you may be having a personal problem that is negatively affecting your job performance. If you require treatment beyond the scope of the Associate assistance counseling sessions, you are responsible for the costs.

Confidentiality

Personal consultation services are confidential. WorkLife Solutions consultants will not release personal information to Transform unless you provide your written consent or the counselor is professionally bound or required by law to do so.

Time Off

Time off from work to seek Associate assistance is subject to Transform's established policies for excused absences; however, it is expected that you will typically seek Associate assistance outside of regular work hours.

TALKSPACE CHATPLUS EAP FEATURE

Utilize Talkspace ChatPlus Counseling to access personalized treatment from licensed therapists and psychiatrists. You can access up to 3 counseling sessions per issue per year. Visit a counselor face to face, online with televideo or get in the moment support by phone.

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the counseling benefits described above under *Associate Assistance*.

IF YOU HAVE AN ELIGIBILITY CLAIM

If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for coverage under the EAP, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - using a Claim Initiation Form to the Transformco Benefits Department at the following address or fax number:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic claim form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE A CLAIM FOR BENEFITS

Forms for filing a claim for benefits under the EAP can be obtained from:

Transform Midco LLC
Benefits Department 5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192

The claims administrator will notify you in writing of its initial claims decision. Such notification will be provided within a reasonable period, not to exceed 90 days after receipt of the claim, unless the claims administrator determines that an extension is necessary (up to an additional 90 days).

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

You or your authorized representative will have 180 days from the date of an adverse determination under the EAP to submit a written request to appeal the determination to the claims administrator at:

Aetna Resources For Living
Attn: Appeals
151 Farmington Ave., RS32
Hartford, CT 06156

You or your authorized representative may submit written comments, documents, or other written information to assist in the review.

Upon receipt of a written request for appeal, the claims administrator will review the case record. The claims administrator may contact you to solicit further information. As necessary, the claims administrator may seek consultation from the account manager. The EAP will review the EAP case record and any additional information submitted by you or your authorized representative and will make a determination.

When you authorize written communication, written notification of the appeal determination will be sent to you or your authorized representative. If you do not authorize written communication, you or your authorized representative will be notified telephonically. Notification of the appeal determination will be provided to you or your authorized representative within the following time frames:

- If the case involves an adverse determination of a request for EAP services or a pre-service adverse determination relating to payment for services, within 30 days of the EAP's receipt of the request for appeal;
- If the case involves a post-service adverse determination relating to payment for services, within 60 days of EAP's receipt of the request for appeal.

Notification of an appeal determination will include the following:

- The specific reason for the review determination;
- Notice of your right to receive, without charge, copies of documents relevant to his/her claim;
- Identification of any of the EAP's rule, guideline or procedure relied upon;
- An explanation of the clinical judgment, where applicable, on which the determination was based; and
- A statement of your right to bring a civil suit under section 502(a) of ERISA within 6 months after you receive an adverse benefit determination on your final appeal.

The decision made on appeal is final and binding.

If you are not satisfied with the decision of the appeal, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must bring such action within 6 months of receiving an adverse benefit determination of your appeal in the U.S. District court of the Northern District of Illinois. No legal action regarding a claim for benefits can be initiated until you have exhausted the claims and appeals procedures.

FOR MORE INFORMATION

The following details about your benefit coverage are provided in the *Other Information* section of this Handbook:

- Coverage continuation for certain benefits; and
- Contact information for benefit claims administrators and insurance carriers.

IMPORTANT NOTE

The WorkLife Solutions Program is a short-term counseling, consultation, resource and referral program. While the benefits described above under *Resource and Referral Services* are not intended to be nor are they treated by Transform as Associate welfare benefits under ERISA, the counseling benefits described above under *Associate Assistance* are treated by Transform as Associate welfare benefits under ERISA.

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ASSOCIATE DISCOUNTS

As a Transform Associate, you may be entitled to discounts on merchandise and services purchased in various Transform retail formats and web sites. This section provides an overview of the Associate Discount programs offered by Transform.

ASSOCIATE DISCOUNT POINTS PROGRAM -- U.S. AND PUERTO RICO

- Once on payroll, U.S. and Puerto Rico Associates who become Shop Your Way members are eligible for discounts on certain merchandise and services purchased from various Transform businesses. The discount is in the form of Shop Your Way Points redeemable on future purchases. Eligibility is determined by the line of business in which you work and subject to the terms and conditions of the Associate Discount Points Program.

ASSOCIATE DOLLARS-OFF DISCOUNT -- GUAM AND THE VIRGIN ISLANDS

- Once on payroll, Guam and Virgin Islands Associates are eligible for discount in the form of dollars-off on certain merchandise and services purchased from various Transform businesses. Eligibility for the dollars-off discount is based on the line of business in which you work and subject to the terms and conditions of the Associate Dollars-Off Discount Policy.

It is your responsibility to understand the eligibility rules that apply to you. Complete details regarding the Associate Discount programs described above, including FAQ's, are located on the Benefits page on **www.88sears.com**.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits; and
- Coverage continuation for certain benefits.

IMPORTANT NOTE

Transform does not intend the Associate Discount programs described in this section to be an Associate welfare benefit plan subject to ERISA.

The fact that the summaries of these programs are included in this Handbook should not be construed as making them subject to ERISA.

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COMMUTER BENEFIT PROGRAM

Transform provides a way for Associates to save on work-related commuting expenses through the Commuter Benefit Program component of the Plan (the "Commuter Benefit Program"). The program allows you to pay for eligible commuting expenses with pre-tax dollars. Part-time hourly Associates are not eligible to participate in the Commuter Benefit Program.

WHAT IS COVERED

The following commuter services are eligible:

- Public Transportation
  - Bus
  - Train
  - Subway
  - Ferry
- Vanpool
  - Vehicle must have seating for 6 or more adult passengers, with 80% of mileage and 50% of seating capacity used for Associate transportation
- Parking
  - Parking at or near work
  - Parking at or near public transportation you use to get to work

Note: Mileage, tolls, fuel, carpooling and business travel are not eligible for this program.

HOW THE PROGRAM WORKS

When you enroll, you select whatever transit product you need for your monthly commute. You can elect:

- Transit
  - You will receive your MyChoice Accounts Visa® card in the mail that can be used to purchase transit passes from your transit authority directly or pay for your vanpool, UberPool or Lyft Shared transportation costs.
- Parking

  You will receive a MyChoice Accounts Visa® card in the mail that can be used to purchase parking from designated kiosks.

You can enroll, change, or cancel your commuter benefits at any time. Payroll deductions are taken from the first pay period of the month.

PRE-TAX VS. AFTER-TAX

You may receive pre-tax benefits up to limits established by the Internal Revenue Service. For 2025, the combined limit for transit and/or vanpooling expenses is $325 per month, and the limit for qualified parking expenses is $325 per month.

Once enrolled, the first $300 in transit and/or vanpool benefits and $300 in parking expenses will be deducted from your paycheck on a pre-tax basis; and the remainder (if any) will be deducted from your paycheck on an after-tax basis. Associates who pay both transit and parking expenses can take advantage of both benefits.

RECEIVING YOUR MYCHOICE ACCOUNTS VISA® CARD

MyChoice, the administrator of the Commuter Benefits Program, will mail the debit card directly to your home. Each month that you are enrolled, funds will be added to the balance on the card through payroll deductions. You may use the card to fund monthly transit passes, purchase transit passes from kiosks, or pay for parking at approved credit card machines.

GETTING REIMBURSED

If for some reason you can't use the card to pay for parking, you may file a claim through your online benefits portal or the MyChoice Mobile App to be reimbursed.

Manual claims for transit expense are not allowed.

WHAT HAPPENS IF MY EMPLOYMENT ENDS OR I STOP BEING ELIGIBLE FOR OTHER REASONS?

If your employment is terminated, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit any balance in your account. You may, however, still be able to get reimbursed for expenses incurred before your participation ended.

WHAT HAPPENS IF I HAVE A CREDIT IN MY COMMUTER ACCOUNT AND I LEAVE THE COMPANY?

Commuter benefits are a "use it or lose it" plan and Associates cannot be refunded for any credits or lost pass claims. Any remaining credits would be forfeited once you leave Transform.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits;
- Coverage continuation for certain benefits; and
- Contact information for benefit claims administrators.

IMPORTANT NOTE

The Commuter Benefit Program is not a welfare benefit plan for purposes of ERISA. It is a tax-advantaged benefit that Transform can offer to Associates under a specific section of the Code.

The fact that a summary of this program is included in this Handbook should not be construed as making it an ERISA plan.

Adoption Assistance Program

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HOW THE PROGRAM WORKS

Transform provides the Adoption Assistance Program component of the Plan (the "Adoption Assistance Program") in recognition of the special needs of Associates who are adopting a child(ren). The Adoption Assistance Program seeks to make the process easier by covering a portion of expenses associated with an adoption. Part-time hourly Associates are not eligible to participate in the Adoption Assistance Program.

***Note*:** Provisions may be different for Associates in different locations, including, but not limited to, Puerto Rico.

ELIGIBILITY

Transform Associates must meet the following eligibility requirements for benefits under this program. The Associate:

- has a salaried or full-time hourly status;
- has completed 12 consecutive months of salaried or full-time hourly service with Transform;
- is adopting a child(ren) under the age of 18; and
- neither Associate, spouse nor domestic partner is related, either biologically or through previous adoption, to the adopted child(ren).

COVERAGE

Under the Adoption Assistance Program, Transform will reimburse 80% of eligible expenses as described below for each eligible adoption, up to a maximum benefit of:

- $5,000 for a single-child adoption (when adopting only one child), or $5,000 for each child in a sibling group adoption; and
- $7,000 for the adoption of a child with special physical and/or medical needs.

Note: The definition of a "special needs" child is as defined by the state in which the Associate resides.

ELIGIBLE EXPENSES

Customary and reasonable expenses eligible for coverage under the Adoption Assistance Program include:

- Legal costs, such as attorney fees;
- Court fees;
- Adoption agency fees;
- Pregnancy expenses for the child(ren)'s birth mother;
- Temporary foster-care expenses;
- Costs for the child(ren)'s required medical examinations; and
- Travel expenses incurred to pick up adopted child(ren).

MAXIMUM NUMBER OF ADOPTIONS

The Adoption Assistance Program will cover eligible expenses for up to two adoptions per family per lifetime, regardless of whether one or both adopting parents are Associates of Transform. This means that an Associate can receive coverage for:

- Two single-child adoptions, or
- One sibling-group adoption.

***Note*:** If both the Associate and spouse are Associates of Transform, only one can apply for reimbursement from the Adoption Assistance Program with respect to an adoption.

PAID TIME OFF

Adopting Associates will be granted paid time off based upon service with Transform. If a married couple both work for Transform and are adopting, only one Associate is eligible for the paid time off benefit (per covered adoption).

- Associates with at least 1 year and less than five years of service are eligible to receive 1 week paid time off at 50% their then weekly current pay.
- Associates with at least 5 years of service would be eligible for 1 week paid time off at 100% of their current weekly pay.

CLAIM SUBMISSION

Claims must be submitted within one year after the adoption is final to receive reimbursement. An adoption is final for purposes of the Adoption Assistance Program when both of the following have occurred:

- The adopted child(ren) is placed in Associate's home; and
- The court finalizes the adoption.

Note: For international adoptions, translated documentation from the country of origin and the VISA validating the final adoption can be used in place of the US court document.

Records of all expenses should be kept and copies made of adoption-related bills that have been paid. Associates should follow these steps when submitting a claim for reimbursement:

1. Obtain an Adoption Assistance Information Kit by calling **1-888-887-3277, option 1** and follow the prompts to speak to a Transform Benefits Center representative.
2. Complete the Adoption Assistance Reimbursement Request Form, and attach all itemized bills, receipts, and other required documentation listed on the claim form for eligible expenses.
3. Mail the completed form to:

   Postal Mail (USPS):

   Transformco Midco LLC
   Benefits Department
   5407 Trillium Boulevard Suite B120
   Hoffman Estates, IL 60192

   Overnight Mail (FedEx, UPS, DHL, etc.):

   Transformco Midco LLC
   Benefits Department
   5407 Trillium Boulevard Suite B120
   Hoffman Estates, IL 60192

The Associate will receive a check for the covered portion of eligible expenses. FICA and, where applicable, state

income taxes will be withheld from reimbursement. Associates may want to consult with a tax advisor regarding these and other taxes that may apply to their reimbursement.

ADOPTION AND OTHER COMPANY BENEFITS

Adopting one or more children qualifies as a change in status under certain other Transform benefit programs. Associates should review other benefit coverage (such as medical, dental, vision, child life insurance, etc.) to determine if they need to make any coverage changes. The effective date of the change in coverage occurs the date the child(ren) is placed in the Associate's home either as a final adoption or placement for finalization of the adoption process (based upon state or international adoption requirements), provided the adoption is reported to the Transform Benefits Center within 31 days after the event.

Associates should address questions to the Transform HR Support Services at **1-888-887-3277**.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- Coverage continuation for certain benefits.
- Contact information for benefit claims administrators and insurance carriers.

IMPORTANT NOTE

The Adoption Assistance Program is not intended to be nor treated by Transform as a welfare benefit plan under ERISA.

The fact that a summary of the Adoption Assistance Program is included in this Handbook should not be construed as making it an ERISA plan.

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GROUP WHOLE LIFE INSURANCE

This Life Insurance policy offered by Allstate is a Whole Life policy, which means it lasts for your entire life, not just a pre-determined time frame. In addition, this policy offers a Long-Term Care rider that will provide funds towards qualified long-term care services should you need them.

HOW THE PROGRAM WORKS

With Group Whole Life Insurance from Allstate Benefits, you get simplified and straightforward coverage.

You decide how much coverage and who to cover (you and/or your eligible dependents) and the level of coverage that fits your needs

You get guaranteed rates for the life of the policy and a guaranteed death benefit to be paid to your beneficiaries. As the policy builds cash value, you can achieve your financial goals or borrow against it should you need to.

Premiums are payable to age 95 and are conveniently payroll deducted. The longer the policy coverage continues and premiums are paid, the more the cash value builds.

You may elect coverage at any time. If you enroll during the annual open enrollment period or after a Qualifying Life Event (QLE) such as marriage or childbirth, there are no medical questions to answer (Guaranteed Issue). If you enroll at any other time, you will be asked several detailed medical questions and you must meet the "Actively at Work" requirement (Simplified Issue).

You lock in affordable rates that are only available through your employer and are guaranteed for the life of your coverage – the younger you are when you elect coverage, the lower your rates will be.

A monthly advance of the death benefit may be paid to help cover the costs associated with long-term care.

Your coverage builds cash value that you may borrow against if needed.

LONG TERM CARE RIDERS

You can receive a monthly advance of 6% of the death benefit for up to 34 months while receiving qualified long-term care services after a 90-day elimination period when certified chronically ill by a licensed health care practitioner. The restoration benefit restores the death benefit and cash value to the pre-acceleration amounts, and the extension benefit extends the long-term care benefit for the period equal to the original benefit term.

MEETING YOUR NEEDS

- Coverage is guaranteed issue for you and your spouse up to age 70 and no medical questions will need to be answered
- Benefits are guaranteed never to reduce for the life of the policy
- Additional coverage is available for your children
- Affordable premiums are conveniently deducted from your paycheck
- Premiums are guaranteed to never increase for the life of the policy
- You can take the coverage with you if you change jobs or retire

USING CASH BENEFITS

Cash benefits provide you with options, because you or your beneficiary get to decide how to use them

Finances: Cash benefits can help protect your HSAs, savings, retirement plans and 401ks from being depleted

Home: Your beneficiary can use the cash benefits to help pay the mortgage, continue rental payments, or perform needed home repairs

Expenses: The cash benefit can be used to help pay for medical and living expenses such as bills, electricity and gas

ADDITIONAL RIDER BENEFITS

Accelerated Death Benefit for Terminal Illness or Condition* - an advance of the death benefit, up to 75% of the certificate face amount, when certified terminally ill.

Accelerated Death Benefit for Long Term Care with Restoration of Benefits and Extension of Benefits** - a monthly advance of 6% of the death benefit for up to 34 months while receiving qualified long-term care services after a 90-day elimination period when certified chronically ill by a licensed health care practitioner. The restoration benefit restores the death benefit and cash value to the pre-acceleration amounts, and the extension benefit extends the death benefit for a period equal to the original benefit term

OPTIONAL RIDER BENEFIT

Children's Term - level term insurance for each covered dependent child under age 26. Not available if dependent child is covered under a separate certificate

CLAIMS INFORMATION

The following information will help you to better understand the claim review and appeal process with respect to the Optional Life Insurance Program.

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Optional Life Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Optional Life Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at the following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

The Transformco Benefits Department will review your claim and notify you of the Plan Administrator's decision in writing. You will generally receive notice within 30 days after the Transformco Benefits Department receives your claim. If the Plan Administrator requires additional time to review your claim, you will be notified within 60 days after the day your claim is received that the Plan Administrator is exercising its right to extend the claim review period up to an additional 60 days to review your claim, or a total of 120 days from the date your claim was received. If your claim is ultimately denied, the notice of such denial will include the following:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

You must complete the appeal process before you can file a lawsuit regarding a denial of your eligibility. Any legal action regarding a denial of your eligibility must be brought within 6 months after you receive the Plan Administrator's denial of your appeal in the U.S. District court of the Northern District of Illinois.

IF YOU HAVE BENEFIT CLAIM

Claim forms may be obtained from American Heritage Life Insurance Company. Also, please see the Death Benefit provision in your certificate of insurance for claim filing guidelines.
American Heritage Life Insurance Company will process the claim, make payment, or issue a denial notice. Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. One 90-day extension will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected. The notice of denial will be written in an understandable manner and include the following:
(a) The specific reason(s) for the denial;
(b) Specific reference to the provision which forms the basis of denial;
(c) A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed; and
(d) An explanation of American Heritage Life Insurance Company's claim review procedures.

HOW TO APPEAL A DENIED CLAIM FOR BENEFITS

The claimant may request an appeal in writing at any time during the 60-day period following receipt of the notice of denial of the claim. American Heritage Life Insurance Company and the Plan Sponsor will consider requests for an appeal of a denied claim upon written application of the claimant or his duly authorized representative. The claimant may, in the course of the appeal, review pertinent documents and submit to American Heritage Life Insurance Company a statement of issues and comments in writing. American Heritage Life Insurance Company will provide the claimant with a written decision providing the final determination of the

claim. This decision will be written in an understandable way, will state the specific reason(s) for the decision and will make specific reference to the provision on which the decision is based. Written notice of the decision will be furnished to the claimant within 60 days after receipt of the claim. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary.

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits; and
- Coverage continuation for certain benefits.

IMPORTANT NOTE

Transform does not intend the Everyday Marketplace programs described in this section to be an Associate welfare benefit plan subject to ERISA.

The fact that the summaries of these programs are included in this Handbook should not be construed as making them subject to ERISA

Everyday Marketplace

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EVERYDAY MARKETPLACE

Everyday provides trusted advice from experts on a wide range of topics and solutions that have been reviewed for quality and reliability. Everyday members get preferred pricing. This ensures you have access to solutions that you can trust and afford. Access resources, advice and coverage anytime you need – no qualifying life event or open enrollment required.

HEALTH& WELLBEING

CAREGIVER ASSISTANCE

Practical tools with personalized support for Associates who are family caregivers. It offers practical support that honors the contributions of a caregiver by building a network for you, expanding your options and providing support 24/7. Contact Caregiver Navigators for assistance with equipment, insurance—or emotional support.

PET INSURANCE

Discounted plans that help cover the costs for injuries, illnesses and preventative care. You're free to choose your preferred vet, including for specialty and emergency care. Take advantage of optional preventative care coverage for routine exams, vaccinations, prescription medications and more. Cover multiple pets in one policy with a Family Plan

PET DISCOUNT

Discounts for pet owners for illness, injuries, preventative care along with Rx and food supply discounts. Save 25% on care at participating veterinarians and up to 40% discounts on food, treats and prescriptions, Chat online with a licensed, U.S.-based veterinarian any time you need with no out-of-pocket costs. Receive a digital ID tag, allowing anyone who finds your lost pet to get your information and contact you

FINANCIAL WELLBEING

STUDENT LOAN ASSISTANCE

Get a custom plan, credit counseling and financial coaching to lower payments and get out of debt. Receive a free expert consultation for lowering student loan debt. Streamline payments for easier money management.

PURCHASING PROGRAM

Purchasing Power is a convenient way to get what you want now. You can shop online then pay for appliances, gym equipment, and electronics and more directly from your paycheck. There's no credit check, no interest added and no hidden service fees compared to store financing or loans. Spread payments into 6- or 12-month payments via easy, automatic paycheck deduction

DISCOUNT PROGRAM

Discount program with deals on thousands of big-name and local brands—all personalized. Buy locally or nationally, online access to exclusive discounts on goods and services.

PERSONAL PROTECTION

AUTO/HOME RENTERS

Everyday provides discounts for policies to help you with costs from unexpected accidents. Save with bundling, safe driver and other Associate discounts. Depending on the insurer you choose, you may be able to pay bills through convenient paycheck deductions. Whether they're for work or play, it cover cars, motorcycles, RVs and watercraft.

Homeowners insurance can help you protect yourself from life's surprises – from fire to theft. Save with bundling, home security and other Associate discounts. Whether you stay or move on from your employer, you'll maintain your coverage for your home.

IDENTITY THEFT

Stay safe with monitoring and alerts of credit reports, bank and credit card activity, and more. Plus, receive device security and online privacy features to further your protection. Monitoring of personal information—like accounts, credit, SSN, and more—plus alerts and security features. Affordable coverage below retail rates, so you won't overpay for peace of mind. Receive help from Identity Restoration Specialists and reimbursement up to your plan limit should fraud or ID theft occur.

LEGAL INSURANCE

Get support and access more than 20,000 attorneys nationwide. Additional guidance is available from Personal Assistance Specialists to save you time and stress. Legal services whenever you need them at a cost effective price. Get connected to an attorney who is right for you in a simple, fast process. A broad range of fully-covered legal matters ensures your family and savings are shielded from legal issues.

CLAIMS INFORMATION

IF YOU HAVE AN ELIGIBILITY CLAIM

If you believe that you have improperly been denied the chance to participate in the Accident Insurance Program, you may file an eligibility claim. If your eligibility for coverage is denied and the denial does not involve a claim for benefits, the decision will be reviewed in accordance with this section. If, however, you file a claim for benefits that is denied because you are not eligible for Accident Insurance coverage, then you are considered to have submitted a claim for benefits, which will be reviewed as described below in the *If You Have a Benefit Claim* provisions of this section.

Note that the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan and will respond to the eligibility and enrollment claims.

To file an eligibility claim, you should submit a written explanation of the reasons for your claim - along with any additional information or documentation - to the Transformco Benefits Department at following address:

Transformco Benefit Department
Attn: Claims and Appeals
5407 Trillium Boulevard Suite B120
Hoffman Estates, IL 60192
BenefitsDepartment@transformco.com
Fax: (520) 542-2210

Contact the Transform Benefit Center at **1-888-887-3277, option 1** to request a Claim Initiation Form.

If you contact the Transform Benefits Center at **1-888-887-3277, option 1** and it is determined that a claim must be filed to resolve the issue, an email will be sent directly to you confirming your intent to file a claim. The email will include a Claim Initiation Form where you will see message titled "Your Action Needed" with an electronic form to complete and submit to the Transformco Benefits Department.

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- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
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- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

To appeal an eligibility claim denial, you should submit, within 60 days of the date of the denial, a written explanation of the reasons for your appeal - along with any additional information or documentation - to the Transformco Benefits Department at the address or fax number listed above,. The Plan Administrator will review your appeal and notify you of its decision in writing. You will generally receive notice within 60 days after the Transformco Benefits Department receives your appeal. If the Plan Administrator requires additional time to review your appeal, you will be notified within 60 days after the day your appeal is received that the Plan Administrator is exercising its right to extend the appeal review period up to an additional 60 days to review your appeal, or a total of 120 days from the date your appeal was received. If your appeal is ultimately denied, the notice of such denial will include the following:

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

YOU MUST COMPLETE THE APPEAL PROCESS BEFORE YOU CAN FILE A LAWSUIT REGARDING A DENIAL OF YOUR ELIGIBILITY. ANY LEGAL ACTION REGARDING A DENIAL OF YOUR ELIGIBILITY MUST BE BROUGHT WITHIN 6 MONTHS AFTER YOU RECEIVE THE PLAN ADMINISTRATOR'S DENIAL OF YOUR APPEAL IN THE U.S. DISTRICT COURT OF THE NORTHERN DISTRICT OF ILLINOIS. IF YOU HAVE A BENEFITS CLAIM.

File a claim or make changes to your policy, please contact your carrier directly. Carrier contact information is provided below. It can also be found on the Everyday Marketplace Help page.

- Norton Life Lock: 1-800-607-9174
- Pet Discount: 1-800-891-2565
- Pet Protection: 855-270-7387
- Purchasing Power: 1-888-923-6236
- Homeowners and Renters Insurance: 1-800-438-6381
- Auto Insurance: 1-800-428-6381
- Student Loan Assistance: info@getfiducius.com
- Legal Protection: 1-713-785-7400
- Associate Discount (Perkspot): 1-866-606-6057
- Caregiver Support: info@ianacare.com

FOR MORE INFORMATION

The following details about your benefits coverage are provided in the *Other Information* section of this handbook:

- When you can make changes to your benefits; and
- Coverage continuation for certain benefits.

IMPORTANT NOTE

Transform does not intend the Everyday Marketplace programs described in this section to be an Associate welfare benefit plan subject to ERISA.

The fact that the summaries of these programs are included in this Handbook should not be construed as making them subject to ERISA

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HIGHLIGHTS

This section contains information on the administration and funding of the benefit programs available to certain full-time (hourly and salaried) and part-time (hourly and salaried Associates of the Company. It completes the information provided in other sections of this Handbook and contains important information about your rights as a participant in these programs.

This section also provides information on ERISA, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and other federal legislation affecting certain benefit programs described in this Handbook. It also provides addresses and phone numbers for the Plan Sponsor, the Plan Administrator, the claims administrators, and other service providers of the benefits programs.

This Handbook is intended to satisfy the SPD requirements under ERISA with respect to those benefit programs that are governed by ERISA. You are strongly encouraged to read the entire SPD and ask questions if you are unsure of any of its terms. After reading this information, we recommend keeping it with your important documents for future reference.

HOW TO USE THIS SECTION

You can use this section as a guide to your benefits—it contains administrative and funding information about the benefit programs. This section also tells you about coverage options after your employment ends or when you go on a leave of absence.

GENERAL ADMINISTRATIVE INFORMATION

Plan Sponsor	Transform Midco LLC
Plan Administrator	Transform Midco LLC Benefits Committee (the "Committee")
Plan Administrator Address	Plan Administrator Transform Midco LLC c/o Benefits Department 5407 Trillium Boulevard Suite B120 Hoffman Estates, IL 60192
Employer Identification Number	Transform Midco LLC: 83-3374195
Participating Employers	A complete list of the Transform affiliates that participate in the Plan may be obtained by submitting a written request to the Plan Administrator. The list is also available for examination by participants and beneficiaries.
Agent For Service of Legal Process	Plan Administrator Transform Midco LLC c/o Benefits Department 5407 Trillium Boulevards Suite B120 Hoffman Estates, IL 60192
Plan Year	Except as noted in this or another section, the Plan is maintained on a calendar year basis, beginning on January 1 and ending on December 31.

Program Names, Numbers, and Type	Program Financing	Program Administration
Medical Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	BCBSIL Basic, Enhanced, and BlueHPN options - Self-insured. Kaiser (HMO) Basic and Enhanced options (California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington or Washington D.C. Associates) - Fully insured. Other HMO options (Puerto Rico, Hawaii, the Virgin Islands or Guam Associates) and Triple S PPO plan (Puerto Rico Associates)- Fully insured. Coverage is paid for by both the Company and pre-tax contributions of active Associates. Contributions made by Associates while on an unpaid leave of absence and while continuing	Sponsor: Transform Blue Cross Blue Shield of Illinois (claims administration and fiduciary responsibility) Express Scripts (claims administration and fiduciary responsibility for prescription drug coverage) Kaiser Permanente (claims administration and fiduciary responsibility for HMO and prescription drug coverage)

Program Names, Numbers, and Type	Program Financing	Program Administration
	coverage under COBRA are made with after-tax dollars. Under the self-insured options, the Company pays the benefits. Under the fully insured options, the insurance company or HMO provider pays the benefits.	Other HMO providers and Triple S (claims administration and fiduciary responsibility) Committee (eligibility administration)
Dental Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Fully insured. Coverage is paid for by pre-tax contributions of active Associates. Coverage is paid for by after-tax contributions for Associates while on an unpaid leave of absence and for continuing coverage under COBRA. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Puerto Rico Dental Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Fully insured. Coverage is paid for by pre-tax contributions of active Associates. Coverage is paid for by after-tax contributions for Associates while on an unpaid leave of absence and for continuing coverage under COBRA. The insurance company pays the benefits.	Sponsor: Transform Triple S (claims administration and fiduciary responsibility) Committee (eligibility administration)
Vision Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Fully insured. Coverage is paid for by pre-tax contributions of active Associates. Coverage is paid for by after-tax contributions for Associates while on an unpaid leave of absence and for continuing coverage under COBRA. The insurance company pays the benefits.	Sponsor: Transform EyeMed Vision Care (claims administration and fiduciary responsibility) Committee (eligibility administration)
Flexible Benefits Program (as it relates to the pre-tax premium conversion and the Health Care and Dependent Care Flexible Spending Accounts) Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Funded solely through Associate contributions.	Sponsor: Transform Businessolver, MyChoice Accounts (claims administration) Committee (eligibility administration)
Short-Term Disability (STD) Program Payroll Practice Non-ERISA plan	Funded solely from general assets of the Company. Claims management services are paid for by the Company through an administrative fee.	Sponsor: Transform New York Life (claims management services) Committee (eligibility administration)
Long-Term Disability (LTD) Program	Insurance contract, funded solely by Associate contributions. The insurance company pays the benefits.	Sponsor: Transform New York Life (claims administration and fiduciary responsibility)

Program Names, Numbers, and Type	Program Financing	Program Administration
Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan		Committee (eligibility administration)
Accident Insurance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Insurance contract, funded solely by Associate contributions. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Critical Illness Insurance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Insurance contract, funded solely by Associate contributions. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Hospital Indemnity Insurance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Insurance contract, funded solely by Associate contributions. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Company Paid Life Insurance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Insurance contract, funded solely by Company contributions. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Optional Life Insurance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Insurance contract, funded solely by Associate contributions. The insurance company pays the benefits.	Sponsor: Transform MetLife (claims administration and fiduciary responsibility) Committee (eligibility administration)
Business Travel Insurance Program	Insurance contract, funded solely by Company contributions. The insurance company pays the benefits.	Sponsor: Transform Life Insurance Company of North America (claims administration and fiduciary responsibility)

Program Names, Numbers, and Type	Program Financing	Program Administration
Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare Plan		Committee (eligibility administration)
WorkLife Solutions, Associate Assistance Program Part of the Transform Health and Welfare Plan Plan number: 501 ERISA welfare plan	Self-funded. Coverage is paid for by the Company through an administrative fee.	Sponsor: Transform Aetna Resources for Living (claims administration) Committee (eligibility administration)
Adoption Assistance Program Non-ERISA plan	Self-funded reimbursement program.	Sponsor: Transform

A NOTE ABOUT THE PLAN ADMINISTRATOR

The Plan Administrator (or its authorized delegates), has the sole discretionary authority to determine eligibility for benefits under the Plan, to determine the amount and form of benefits payable under the Plan, to construe the terms of the Plan, and to make factual determinations about all Plan matters. The decisions of the Plan Administrator or its delegate(s) are final and binding.

The Plan Administrator may appoint one or more persons to carry out the responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator will be entitled to rely upon the information and advice furnished by such delegate(s) and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate(s) shall have full discretionary authority to determine eligibility for Plan benefits, to make factual findings and to interpret the terms of the Plan. Any interpretation or determination based on this discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Plan benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that the applicant is entitled to them under the terms of the Plan.

The Plan Administrator has engaged claims administrators (as indicated in the previous chart and shown later under the heading "Claims Administrators/Insurance Companies") to administer claims for benefits and to provide certain services under the Plan. The claims administrators will authorize payment of claims or services in accordance with the Plan, but with respect to the self-funded benefits are not insurers of the Plan; they provide only administrative services for the Plan. The Committee retains full responsibility as Plan Administrator and as named fiduciary for eligibility decisions, and Transform is responsible for funding the benefits under the self-funded benefits as long as they are in effect.

Under the benefit options of the Medical Program, the Plan Administrator has delegated the authority for claims determinations and appeals of denied claims to the third-party administrators and insurance carriers that provide coverage for medical claims, pharmacy benefits, mental health and substance abuse and medical management decisions. The foregoing is subject to the Plan Administrator's retention of full responsibility as Plan Administrator and as named fiduciary for eligibility decisions.

PLAN DOCUMENTS

This Handbook contains the provisions of the Transform benefit programs as they apply to full-time (hourly and salaried) and part-time (hourly and salaried) Associates and their dependents.

Unless otherwise specified, this Handbook and the insurance documents and other incorporated by reference, as applicable, represent a SPD required by

ERISA with respect to the programs under the Plan that are governed by ERISA.

The benefits and other principal provisions described in this Handbook with respect to a particular program apply to you only if you are eligible to participate, become covered by the program, and remain covered in accordance with the provisions of such program.

GENERAL INFORMATION ABOUT YOUR BENEFITS

Below is information on rules that affect your eligibility for benefits. For all programs, coverage ceases as of the earlier of the date specified under the heading "Termination of Coverage" below or the date the program is terminated or modified to terminate coverage for the specified class of Associates or dependents to which you belong.

CHANGES IN COST OF COVERAGE

If the cost of group health coverage increases or decreases by an insignificant amount (as determined by the Plan Administrator) during a plan year, the Plan Administrator may, on a reasonable and consistent basis, provide that the cost of coverage to be charged to you under the affected plan be automatically adjusted on a prospective basis. If the cost of group health coverage to be charged to you increases by a significant amount (as determined by the Plan Administrator) during a plan year, you will have the right to make a corresponding change to your coverage election.

QUALIFIED CHANGES IN STATUS

Certain events enable you to change your group health coverage choices during the year for the benefits described below. These events are defined by federal law. In other circumstances, the Plan has set rules governing coverage changes. These are collectively called "qualified changes in status." Except as otherwise specified, changes made as a result of a qualified change in status must be made within 31 days of the event and must be consistent with that event, as shown in the following chart. The change in status must also result in the Associate, spouse or dependent gaining or losing eligibility for health coverage.

Medical, Dental and Vision. Coverage changes may be made in accordance with the chart on the following pages. These rules do not apply to the HSA under the HDHP.

Flexible Spending Accounts (FSAs). Changes can be made at the time of a qualified change in status. The change must be consistent with the qualified status change. For example, if you add a new eligible dependent, you can enroll or increase your contributions in the FSAs. The change becomes effective the first of the month following your request.

You may also be able to change contributions to your

Dependent Care FSA if you change day care providers during the year and/or your provider's cost changes.

Commuter Benefits Program. Changes may be made at any time, subject to monthly deadlines.

Qualified Status Changes - Changes You Can Make To Your Benefit Programs		
Life Event	**Medical, Dental and Vision**	
	If you are already enrolled	**If you are not already enrolled**
Marriage	▪ Add your spouse and/or eligible dependent children ▪ Cancel coverage for yourself or any dependent children who gain eligibility for and become covered by your spouse's plan ▪ Change plan options	▪ Enroll yourself ▪ If you enroll, you may enroll your spouse and/or eligible dependent children
When change is effective	*If enrolling or changing plan options, the first of month following eligibility and enrollment.* *If canceling coverage, end of month request is submitted.*	
Divorce, legal separation or annulment*	▪ Cancel coverage for your former spouse ▪ Add your eligible dependent children who lost coverage under your spouse's plan ▪ Change plan options	▪ Enroll yourself if you lost coverage under your former spouse's plan ▪ If you enroll, you may enroll your eligible dependent children who lost coverage under your spouse's plan
When change is effective	*If enrolling or changing plan options, the first of month following eligibility and enrollment.* *If canceling coverage, end of month request is submitted.*	
Birth, adoption or placement for adoption of a child	▪ Add spouse and/or eligible dependent children ▪ Change plan options	▪ Enroll yourself ▪ If you enroll, you may enroll your spouse and/or eligible dependent children

Qualified Status Changes - Changes You Can Make To Your Benefit Programs		
Life Event	**Medical, Dental and Vision**	
	If you are already enrolled	**If you are not already enrolled**
When change is effective	*For Medical: Date of birth, adoption, or placement for adoption* *For Dental and Vision: First of month following eligibility and enrollment*	
Death of spouse	▪ Cancel coverage for your spouse ▪ Add eligible dependent children who lost coverage under your spouse's plan ▪ Change plan options	▪ Enroll yourself if you lost coverage under your spouse's plan, and ▪ If you enroll, you may enroll your eligible dependent children who lost coverage under your spouse's plan
When change is effective	*If enrolling or changing plan options, the first of month following eligibility and enrollment.* *If canceling coverage, end of month request is submitted.*	
Death of dependent	▪ Cancel coverage for your dependent	N/A
When change is effective	*End of month request is submitted.*	
Dependent child's loss of eligibility under the Plan*	▪ Cancel coverage for your ineligible dependent (mandatory cancellation–COBRA will be offered)	N/A
When change is effective	*End of month request is submitted.*	
You, your spouse and/or dependent child's loss of eligibility or coverage under another employer plan or a governmental or educational institution plan (includes **▪ Change in coverage due to your spouse's open enrollment election** **▪ COBRA)**	▪ Add your spouse and/or eligible dependent(s) who lost coverage ▪ Change plan options	▪ Enroll yourself ▪ If you enroll, you may enroll your spouse and/or eligible dependent children who lost coverage
When change is effective	*First of month following eligibility and enrollment.*	
Approval of Qualified Medical Child Support Order (QMCSO)	▪ Add eligible dependent child in accordance with QMCSO	▪ Enroll yourself and your eligible dependent child in accordance with QMCSO
When change is effective	*First of month following eligibility and enrollment.*	
Relocation or other change in employment status (*e.g.*, taking a leave of absence, change in work schedule) resulting in change in plan eligibility	▪ Cancel coverage or add coverage to the extent consistent with the change ▪ Change plan options for yourself, your spouse and/or covered dependents	N/A

Qualified Status Changes - Changes You Can Make To Your Benefit Programs		
Life Event	**Medical, Dental and Vision**	
	If you are already enrolled	**If you are not already enrolled**
When change is effective	*If changing plan options, the first of the month following eligibility and enrollment.* *If canceling coverage, end of month request is submitted.*	
You, your spouse and/or dependent child gain eligibility under another employer plan or under a qualified health plan offered through a Health Insurance Marketplace	▪ Cancel coverage for you, your spouse and/or eligible dependent(s) to enroll in another plan. ▪ If the other plan is a qualified health plan offered through a Health Insurance Marketplace, you must: (i) seek to enroll during a special enrollment period or annual enrollment period for the Marketplace; and (ii) intend to enroll yourself and your covered dependents (your spouse and eligible children) in the qualified health plan effective no later than the day following the last day you and your dependents have Transform coverage.	N/A
When change is effective	*End of month request is submitted.*	
You or your dependent's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility	You and your dependent may enroll in the Medical Program if you request coverage not later than 60 days after termination of the Medicaid or CHIP coverage	N/A
When change is effective	*End of month request is submitted.*	
You or your dependent becomes eligible for a premium assistance program (that can be used towards Medical Program costs) under Medicaid or a state Children's Health Insurance Program (CHIP)	You and your dependents request coverage under the Medical Program for you and your dependents no later than 60 days after the date of the event.	N/A
When change is effective	*End of month request is submitted.*	
You move from a full- to a part-time position (even though you remain eligible for Medical Program coverage through the end of the year in which the move occurs).	▪ Cancel coverage for you, your spouse and/or eligible dependent(s) to enroll in a minimum essential coverage plan (such as Marketplace coverage or coverage through another employer plan) ▪ You must intend to enroll yourself and your covered dependents (your spouse and eligible children) in the minimum essential coverage no later than the first day of the second month following your cancellation of Transform coverage.	N/A

Qualified Status Changes - Changes You Can Make To Your Benefit Programs		
Life Event	**Medical, Dental and Vision**	
	If you are already enrolled	**If you are not already enrolled**
When change is effective	*End of month request is submitted.*	
**You must notify the Transform Benefits Center of these events immediately.*		

CONTINUING YOUR BENEFITS DURING A LEAVE OF ABSENCE

The following chart describes the benefits you may continue during certain authorized leaves of absence. (Please note: some exceptions apply under collective bargaining agreements.) If you are on a leave of absence that is not listed below, then you are not eligible to have benefits covered during that leave, except as otherwise required by law. Also, if your authorized leave is listed below, but a particular benefit program or coverage type is not listed under that type of leave, then you are not eligible for that benefit program or coverage during your leave.

Important Note Regarding Payment for Benefits While on Leave: If you are eligible to continue coverage based on your leave, you must continue to pay required contributions to remain on the benefit program during your leave. Part-time hourly Associates become eligible for Medical Program coverage under the special ACA rules explained in the Introduction section of this Handbook (see "Special Eligibility Rules for Part-Time Associates"). For part-time hourly Associates, the chart below explains the impact, if any, of various leaves on Associates who are already eligible for Medical Program coverage. If you are on a paid or unpaid leave, you will be billed monthly for your contributions on an after-tax basis through a direct bill invoice. Your pre-tax contributions will resume on a payroll deduction basis effective the first of the following month when you return from leave. However, you may change your election by contacting the Transform Benefits Center within 31 days. (Your eligibility date is the first day of the month after you return from your leave of absence.)

Type of Leave of Absence	Benefits Continuation
Family Medical Leave (FML) or Extended Care Leave (ECL) - (Unpaid unless you are also on Short-term Disability, receiving or using vacation/personal holidays. Also includes leaves paid through Workers' Compensation)	You may continue coverage (or remain eligible for coverage, as applicable) during FML or ECL under the following benefit programs: • *Medical, Dental, Vision and Health Care FSA* - provided you otherwise remain eligible and you continue to make the required contributions. • *Short-Term Disability* - excluding leaves paid through Workers' Compensation. • *Long-Term Disability* - Note that if you do not make required contributions during your leave, coverage will terminate and, upon return from leave of absence, you will need to reapply for coverage to have your coverage reinstated, and evidence of good health will be required. • *Company Paid Life Insurance* • *Optional Life Insurance* - Note that if you do not make required contributions during your leave, coverage will terminate and, upon return from leave of absence, you will need to reapply for coverage to have your coverage reinstated, and evidence of insurability will be required. • *WorkLife Solutions* • *Associate Discounts* • *Adoption Assistance Program* Participation in the following benefit programs ceases during your leave: • *Dependent Care FSA* - Once you return from your leave, you may elect to participate in the Dependent Care FSA if you re-enroll within 31 days of your return to work. • *Health Savings Account* - New elections may be made upon return from leave if you are enrolled in a Transform-offered HDHP for medical coverage. Please note, prior HSA deductions will not reinstate upon return unless a new election is made. • *Business Travel Insurance* • *Commuter Benefits Program* - New elections may be made upon return from leave.

Type of Leave of Absence	Benefits Continuation
Personal Leave - (Unpaid)	You may continue coverage during a Personal leave under the following benefit programs: • *Medical, Dental, Vision and Health Care FSA* - provided you otherwise remain eligible and you continue to make the required contributions. • *Optional Life Insurance* • *WorkLife Solutions* • *Associate Discounts* • *Adoption Assistance Program* Participation in the following benefit programs ceases during your leave: • *Dependent Care FSA* - once you return from your leave, you may elect to participate in the Dependent Care FSA if you re-enroll within 31 days of your return to work. • *Health Savings Account* - New elections may be made upon return from leave if you are enrolled in a Transform-offered HDHP for medical coverage. Please note, prior HSA deductions will not reinstate upon return unless a new election is made. • *Short-term Disability* • *Long-term Disability* - Upon return from leave of absence, you will need to reapply for coverage to have your coverage reinstated, and evidence of good health will be required. • *Company Paid Life Insurance* • *Business Travel Insurance* • *Commuter Benefits Program* - New elections may be made upon return from leave.
Military Leave – (Paid or Unpaid)	You may continue coverage (or remain eligible for coverage, as applicable) during a Military leave for up to the period described below for the applicable benefit programs. Note that any period of USERRA continuation coverage available to you runs concurrently with the period your benefits are continued: • *Medical, Dental, Vision and Health Care FSA* – provided you otherwise remain eligible and you continue to make required contributions. • *Company Paid Life Insurance* • *Optional Life Insurance* • *WorkLife Solutions* • *Associate Discounts* • *Adoption Assistance Program* Participation in the following benefit programs ceases during your leave: • *Dependent Care FSA* - Once you return from your leave, you may elect to participate in the Dependent Care FSA if you re-enroll within 31 days of your return to work. • *Health Savings Account* - New elections may be made upon return from leave if you are enrolled in a Transform-offered HDHP for medical coverage. Please note, prior HSA deductions will not reinstate upon return unless a new election is made. • *Short-term Disability* • *Long-term Disability* - Upon return from leave of absence, you will need to reapply for coverage to have your coverage reinstated, and evidence of good health will be required. • *Business Travel Insurance* • *Commuter Benefits Program* - New elections may be made upon return from leave.

Other Time Away from Work	Benefits Continuation
Seasonal Layoff (Unpaid)	You may continue coverage during a Seasonal Layoff under the benefit programs listed below. • *Medical, Dental, Vision and Health Care FSA* - provided you otherwise remain eligible and you otherwise remain eligible for the Plan and continue to make required contributions. • *Optional Life Insurance* • *WorkLife Solutions* • *Associate Discounts* Participation in the following benefit programs ceases during a Seasonal Layoff: • *Dependent Care FSA* - Once you return to work, you may elect to participate in the Dependent Care FSA if you re-enroll within 31 days of your return to work. • *Health Savings Account* - New elections may be made upon return to work if you are enrolled in a Transform-offered HDHP for medical coverage. Please note, prior HSA deductions will not reinstate upon return unless a new election is made. • *Short-term Disability* • *Long-term Disability* - Upon return to work, you will need to reapply for coverage to have your coverage reinstated, and evidence of good health will be required • *Company Paid Life Insurance* • *Business Travel Insurance* • *Commuter Benefits Program* - New elections may be made upon return.

TERMINATION OF COVERAGE

Benefit	When Coverage Ends
Medical, Dental and Vision Coverage	Coverage for you as an Associate ends on the earliest of the following: ▪ December 31 if you cancel your payroll deduction authorization for Associate coverage during an annual enrollment period; ▪ For part-time hourly Associates, December 31 if your "hours of service" for the relevant measurement period are such that you will not be eligible for Medical Program coverage for the following year (See "Special Eligibility Rules for Part-Time Hourly Associates" in the *Introduction* section of this Handbook); ▪ Last day of the month in which employment ends:: - You are no longer an eligible Associate (Note: if you move to a part-time hourly position, you will remain eligible through the end of the plan year); - You terminate employment or retire; or - You last made a required contribution. Coverage for your dependents ends on the earliest of the following: ▪ December 31 if you cancel your payroll deduction authorization for dependent coverage during an annual enrollment period; ▪ For part-time hourly Associates, December 31 if your "hours of service" for the relevant measurement period are such that you will not be eligible for Medical Program coverage for the following year (See "Special Eligibility Rules for Part-Time Associates" in the *Introduction* section of this Handbook); ▪ The date your coverage terminates; or ▪ The end of the month in which: - Your dependent is no longer an eligible dependent - You request that dependent coverage terminates as a result of a qualified change in status; or - You fail to pay any required contribution for dependent coverage.

Benefit	When Coverage Ends
	Coverage for a dependent child whose coverage is ending because he or she has reached age 26 may continue beyond the date it would otherwise terminate if (provided you remain eligible for coverage): ▪ The dependent is incapable of self-sustaining employment because of mental or physical disability; ▪ Is wholly dependent on you for financial support; and ▪ You provide satisfactory proof of these qualifications on an annual basis. ***Extension of Dental Benefits*** Coverage for a dental procedure that was started before dental coverage ends will be extended for charges incurred for no more than 30 days after coverage ends, for the following services only: ▪ Impressions that have been taken from which dentures, crowns or fixed bridgework will be made; and ▪ Fixed bridgework and crowns where the teeth have been fully prepared, if they will serve as retainers or support or they are being restored. The extension of coverage applies only if the item is finally installed or delivered no more than 30 days after coverage ends.
Health Care FSA	You are no longer eligible to participate in the Health Care FSA upon: ▪ Termination of employment; ▪ Retirement; ▪ Change to part-time hourly status; or ▪ Failure to make a required contribution
Dependent Care FSA	You are no longer eligible to participate in the Dependent Care FSA upon: ▪ Termination of employment; ▪ Retirement; ▪ Change to part-time hourly status; ▪ Failure to make a required contribution; or ▪ Any type of leave of absence, or Seasonal Layoff. Upon return from a leave of absence or reinstatement, you may reinstate your Dependent Care FSA elections within 31 days of your return to work.
Health Savings Account	Pre-tax contributions ends upon termination of employment or the date you are no longer enrolled in a Transform offered HDHP
Short-Term Disability and Long-Term Disability	Your coverage under the Short-Term Disability Program and the Long-Term Disability Program ends on the earliest of the following dates: ▪ For Short-Term Disability, the day your employment ends (coverage ends on the last day of employment), for Long-Term Disability, coverage ends 14 days after your last day of employment; ▪ Retirement (coverage ends on the last day worked); ▪ The day you die; ▪ The day prior to the day your employment changes to an ineligible status (for example, part-time hourly); or ▪ The day prior to the day you begin a leave of absence (other than a FML or ECL).
Business Travel Insurance	Coverage ends on the date you terminate or retire.
Company Paid Life Insurance and	Coverage ends on the earliest of the following dates: ▪ The day your employment ends;

Benefit	When Coverage Ends
Optional Life Insurance	▪ The date of your death; ▪ The day prior to an employment status change that affects your eligibility for coverage; ▪ The day prior to being placed on a Personal leave or Seasonal Layoff; or ▪ The day the Plan terminates.
Commuter Benefit	Participation ends upon termination of employment.

COORDINATION OF BENEFITS

MEDICAL, DENTAL, VISION

If you elected an option under the Medical Program, the Dental Program and/or the Vision Program, the third-party administrator's booklet or the insurance carrier's certificate of coverage controls the coordination of benefits between your chosen coverage option and any other medical, dental or vision coverage you have. Please contact the insurance carrier for the program in which you are enrolled for details.

OTHER MEDICAL PROGRAM COVERAGE INFORMATION

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A qualified medical child support order (QMCSO) is an order or judgment from a state court, or an order issued under an administrative process established under law, that meets the applicable qualification requirements. It is served on a plan or its agent for service of legal process and directs the plan to cover the dependent child(ren) of an eligible Associate for benefits under certain Transform-sponsored program. Coverage is provided in accordance with federal and applicable state law and the terms of the Plan. If you become subject to a QMCSO, you and each child will be notified about further procedures to validate and implement the QMCSO.

A copy of the Plan's QMCSO procedures can be obtained, without charge, from the Transform Benefits Center.

CONTINUATION OF COVERAGE UNDER COBRA OR USERRA

Federal legislation provides for certain circumstances under which you and your dependents can continue certain health care coverage that would otherwise end.

You and your dependents who would otherwise lose coverage under certain circumstances may choose to continue medical, dental, vision, and Health Care FSA coverage, at your own expense, under COBRA, or USERRA for Military leave.

If you are eligible for coverage as a result of COBRA or USERRA, you may change your coverage each year during the annual enrollment period or if you have a qualified change in status.

HOW COBRA WORKS

COBRA continuation coverage provides the same medical, dental and vision coverage that is available to active Associates. However, when COBRA coverage is elected you or your dependent(s) are responsible for the full cost of the continued medical, vision and/or dental coverage (including any portion formerly paid by Transform) plus an administrative fee, which currently is 2%. If you elect to continue coverage for your Health Care FSA, your contributions will be equal to 102% of the contributions you were making at the time you lost eligibility. Payment must be made on an after-tax basis in accordance with the instructions that will be issued to you by the Transform Benefits Center.

You can elect continued medical, vision and/or dental coverage for yourself and/or your covered dependents under the Transform Medical, Dental and Vision Programs. Each covered individual has an independent right to elect continuation coverage even if you do not elect it on their behalf.

COBRA continuation of your Health Care FSA coverage may only continue until the end of the current calendar year. The length of COBRA continuation coverage for medical, dental or vision depends on the reason for the loss of coverage – see the chart below.

Qualifying Event	Medical Dental and Vision Maximum Coverage Period:
Associate's reduced work hours or employment reclassification causing ineligibility for coverage	18 months
Associate's termination or retirement (except for gross misconduct)	18 months
Associate's death	36 months
Divorce, legal separation or annulment	36 months
Dependent child's loss of eligibility (for example, by reaching the age limit, getting married or becoming a Transform Associate)	36 months

In the case of divorce, legal separation or annulment or a dependent child's loss of eligibility, it is the responsibility of the Associate, family member or dependent to notify the Transform Benefits Center at **1-888-887-3277** within 60 days of the event. Upon receipt of timely notification, the dependent losing coverage will be sent a COBRA election notice.

You or your dependents have 60 days from the later of the following to elect continuation of coverage:

- The date of the event that made you or your dependents first eligible for the continuance; or
- The date you or your dependents received a COBRA election notice.

Coverage will terminate before the end of the maximum COBRA period for any of the following reasons:

- Nonpayment of contributions;
- Coverage under another group medical, dental or vision plan after electing COBRA coverage, unless that plan contains a pre-existing condition limitation that affects you or a covered dependent;
- Becoming entitled to Medicare after electing COBRA coverage; or
- Termination of the Plan.

If you or your dependents do not elect continuation of coverage, the coverage for you or your dependents will terminate.

Extension of 18-month coverage period

If you elect continuation coverage, and the applicable maximum coverage period is 18 months, an extension of this maximum period may be available if you, your spouse, or covered dependent is disabled or a second qualifying event occurs.

- An 11-month extension of coverage may be available if any of the covered family members is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The SSA's disability determination must be received within the disabled individual's 18 months of continuation coverage. You must notify the Transform Benefits Center at **1-888-887-3277, option1** of the SSA's disability determination within 60 days of the disabled individual's receipt of the disability award. If the disability determination occurred before COBRA coverage started, you must notify the Transform Benefits Center at **1-888-887-3277**, Option 1 within the first 60 days of COBRA coverage. If the disabled individual is determined by the SSA to no longer be disabled, you, your covered spouse, or your covered dependents must notify the Transform Benefits Center at **1-888-887-3277, option 1** within 30 days after SSA's determination.
- An 18-month extension of coverage may be available to your spouse and dependent children who elect continuation coverage if a second qualifying event occurs during their first 18 months of COBRA coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. The second qualifying events include:
  - Your death
  - Your divorce or legal separation
  - A dependent's loss of eligibility for coverage under the plan

  To receive this additional coverage, you, your covered spouse, or your covered dependents must notify the Transform Benefits Center at **1-888-887-3277, option 1** within 60 days after a second qualifying event occurs.
- If you take a leave of absence that qualifies as a leave under USERRA, and you elect COBRA continuation coverage, an extension of 6 months may be available to you. If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid for medical coverage before the leave. However, if the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of coverage for active Associates.

If you are covered by a fully insured California option, you may be eligible for up to an additional 18 months of continued coverage under that HMO (for a total period of 36 months) once your federal COBRA coverage ends. This coverage is provided under the California Continuation Benefits Replacement Act (Cal-COBRA). Please contact the insurer directly for additional information once your federal COBRA coverage ends.

OPTIONS BESIDES COBRA

You may have other options available to you when you lose Medical Program coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

CONTINUATION OF EAP BENEFITS

Your benefits under the EAP feature of the Worklife Solutions program automatically continue for 90 days following your termination of employment.

CLAIMS INFORMATION

Please refer to the relevant section for each applicable ERISA-governed benefit in this Handbook for information on how to file a claim for benefits, as well as the timeframes for responding to initial claims. For claims

information relating to the Medical Program, please also refer to the third-party administrator's booklet or the insurance company's certificates of coverage and documentation for the coverage option you choose.

CLAIMS ADMINISTRATORS/INSURANCE COMPANIES

Program	Claims Administrator or Insurer
Medical Program ▪ PPO/HDHP/BlueHPN Options	BCBSIL Basic (HDHP) and Enhanced (PPO) Options: Blue Cross Blue Shield of Illinois BCBSIL P.O. Box 805107 Chicago, IL 60680-4112 **1-855-547-1393** **www.bcbsil.com/transform** BlueHPN Option: Blue Cross Blue Shield of Illinois BCBSIL P.O. Box 805107 Chicago, IL 60680-4112 **1-800-538-8833** **www.bcbsil.com/transform** Prescription Drug Coverage under BCBSIL Options: Express Scripts ATTN: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 Triple S PPO: Refer to your booklet or certificate of coverage, or call the member services number on your identification card.
▪ HMO Options	Kaiser HMO Options: Refer to your Kaiser member handbook or certificate of coverage. You may also call the number on your identification card or visit **https://my.kp.org/transform/contact-member-services**. Other HMO Options: Refer to your HMO member handbook.
Dental Program	MetLife Dental Claims P. O. Box 981282 El Paso, TX 79998-1282 **1-800-942-0854**
Vision Program	EyeMed Vision Care *Claims:* **1-866-565-1538** *Appeals:* FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: 1-513- 492-3259
Health Care and Dependent Care FSAs	MyChoice Accounts MSC 345475 PO Box 105168 Atlanta, GA 30348-5168 Fax 855-883-8542 To send claims electronically, use the MyChoice Accounts mobile app by Businessolver.
Short-Term Disability (STD) Program	*Claims:* New York Life, **1-800-828-6352** *Appeals:* New York Life Group Benefit Solutions Paper Intake Team P.O. Box 709015 Dallas, TX 75370-9015 Fax: 1-800-642-8553

Program	Claims Administrator or Insurer
	Email: GBSIntakePaper@newyorklife.com
Long-Term Disability (LTD) Program	*Claims:* New York Life **1-800-828-6352** *Appeals:* New York Life Group Benefit Solutions Paper Intake Team P.O. Box 709015 Dallas, TX 75370-9015 Fax: 1-800-642-8553 *Email*: GBSIntakePaper@newyorklife.com
Supplemental Medical (Accidental Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance)	Claims and Appeals: Metropolitan Life Insurance Company P.O. Box 80826 Lincoln, NE 68501-0826 1 800- GET-MET8 (1-800-438-6388) Fax: 1-855-306-7350 Submit a claim online by visiting mybenefits.metlife.com or download the MetLife Mobile App
Company Paid Life and Optional Life Insurance Program	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 **1-800-638-6420**
Business Travel Insurance Program	Report claim to: Transform Midco LLC Risk Management Dept. 768RM 5407 Trillium Boulevard Suite B120 Hoffman Estates, IL 60192 **1-847-286-2500** AIG Claims Administration P.O. Box 25987 Shawnee Mission, KS 66225 **1-800-551-0824**
WorkLife Solutions, EAP	Aetna Resources For Living Attn: Appeals 151 Farmington Ave., RS32 Hartford, CT 06156 **1-800-424-4732**

MISCELLANEOUS INFORMATION

The following information pertains to certain programs (as indicated) and to you as a participant in such programs. The certificates of coverage issued by the insurance companies may contain more detailed information on the topics addressed below and should be consulted to determine rules specific to the applicable insurance company.

PROTECTIONS FOR THE PROGRAMS

The insurance companies that issue the insurance certificates for any of the insured programs described in this Handbook may have reserved rights to recover benefit payments, to coordinate benefits, to be reimbursed for certain payments, and to subrogate where other people may be liable for damages. Be sure to check the applicable certificate of coverage issued by your insurer to determine what those protections are.

NON-ASSIGNMENT OF BENEFITS

Generally, benefits or a right of a benefit may not be assigned or transferred in any manner except as required by law, unless otherwise stated in this Handbook.

Except for tax withholding, an IRS lien or a qualified domestic relations order (described below), you may not legally assign your benefit or right to a benefit under the Plan to another person or alienate the Plan in any way. You may not sell, transfer, pledge or otherwise use your benefits to obtain credit in any form. The Plan is not liable for, or subject to, and will not pay, any debts or obligations of a participant who becomes eligible for benefits.

IF YOU BECOME INCOMPETENT

If benefits are payable to you and the Plan Administrator determines that you are unable to care for your financial affairs, then any payment due you may be made to your

legal representative or to a relative or person who is taking care of you. Alternatively, the Plan Administrator may direct the application of your benefit in any manner selected by the Plan Administrator, which is permitted by law and is consistent with the Plan.

LTD benefits will be paid to the Associate. If any person to whom LTD benefits are payable is a minor or, in the opinion of New York Life, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment of LTD benefits has been made by the legal guardian, New York Life may, at its option, make payment to the person or institution appearing to have assumed custody and support. If an Associate dies while any LTD benefits remain unpaid, New York Life may, at its option, make direct payment of LTD benefits to any of the following living relatives of the Associate: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Associate's estate. New York Life may reduce the LTD amount payable by any indebtedness due.

Payment in the manner described above will release Transform and/or the applicable insurance company from all liability for any payment made.

CLERICAL ERROR

A clerical error will not void coverage that should be in force nor will it continue coverage that should have ended. When an error is found, an appropriate adjustment in any contribution will be made. However, clerical and payroll errors not reported by a participant (or beneficiary) within 12 months will not be corrected, unless otherwise required by law. In such cases, reinstatement of lapsed coverage caused by payroll or clerical error will be subject to normal plan rules for re-enrollment and evidence of insurability, if applicable.

An error in claims processing will not set precedent for future benefits. Also, verbal misinformation from a telephone representative or manager that goes against the intent of the Plan cannot supersede this document or the respective plan document. Errors in written communications cannot supersede this document or the respective plan document.

RIGHT TO INVESTIGATE A CLAIM

The Plan Administrator or its delegate has the right to investigate any claim and may seek the opinion or services of outside consultants.

MISREPRESENTATION OF ELIGIBILITY OR CLAIM INFORMATION

Your participation in the Plan and that of your dependents will be terminated if, while enrolling or enrolled in the Plan, you or your covered dependents knowingly and intentionally:

- Submit any materially false information;
- Conceal any information material to enrollment in the Plan; or
- Assist another person to submit or conceal any such information.

Your participation in the Plan and that of your dependents will be terminated if, when submitting a claim for benefits under the Plan, you or your covered dependents knowingly and intentionally:

- Include any materially false information;
- Conceal any information material to the claim; or
- Assist another person to submit or conceal any such information.

Note: If your participation is terminated as described, coverage for any dependent also will be terminated even though your dependent took no part in your actions, unless such dependent has an independent right to continuation in the Plan or extension of benefits.

MATERIAL MISSTATEMENTS OR OMISSIONS

At all times, it is necessary to provide accurate and complete information. A material misstatement or failure to disclose important information could result in payment of benefits in error for someone who is ineligible for coverage.

If this occurs, the Plan Administrator may rescind coverage, subject to appropriate review procedures as required by ERISA. You will be obligated to refund to the Plan any benefit payments resulting from the material misstatements or omissions, less overpaid contributions. You will be obligated to refund such benefit payments to the Plan even if you make an unintended material misstatement or omission.

If your age or your dependent's age is misstated, the correct age will be used to determine if coverage is in effect and your benefits and/or premiums under the LTD and Optional Life Programs will be adjusted accordingly.

No statement made by you can be used to contest your coverage after your coverage has been in effect for two years. No statement you make can be used to contest your coverage unless it is in writing and signed by you, and a copy was given to you.

NOTE FOR KEY AND HIGHLY COMPENSATED ASSOCIATES

Key and highly compensated Associates are generally participants who are highly paid, as defined by the Code. The Plan Administrator will notify you if you are classified within these categories and it has an implication on your participation in any of the benefit programs. For example, if you are a "highly compensated Associate" (using IRS guidelines), then you are not eligible to participate in the Dependent Care FSA.

CONFLICT WITH PLAN DOCUMENTS

This Handbook summarizes the benefits that are offered to eligible Transform salaried and hourly Associates. The Plan is governed by the text of the official plan document(s) and/or insurance policies that provide the benefits under the Plan. If there is a conflict between this Handbook and the text of the plan document(s) and

insurance policies, the plan document(s) and insurance policies will govern. The Plan document, along with the relevant provisions of this Handbook and applicable insurance policy constitute the plan document:

- Medical Program
- Dental Program
- Vision Program
- WorkLife Solutions
- Company Paid Life Insurance Program
- Optional Life Insurance Program
- Long-Term Disability Insurance Program
- Accident Insurance Program
- Critical Illness Insurance Program
- Hospital Indemnity Insurance Program
- Business Travel Insurance Program

EMPLOYMENT RIGHTS NOT GUARANTEED

Your participation in any of the benefit programs under the Plan does not assure you of continued (or renewed) employment with the Company or rights to benefits except as specified under the terms of the Plan. This SPD is not a contract of employment.

PLAN AMENDMENT OR TERMINATION

Although Transform expects to continue the Plan, Transform reserves the right to modify, amend, suspend or terminate the Plan at any time and for any reason.

USERRA RIGHTS

Notwithstanding any provision of the Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with Code Section 414(u) and USERRA.

NOTICE OF PRIVACY PRACTICES

This section of the Handbook contains the Notice of Privacy Practices (hereinafter, the "notice").

THIS NOTICE DESCRIBES:

I. HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION; AND THE PLAN'S LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the group health plan components of the Transform Health and Welfare Plan (hereinafter referred to as the "Plan") to protect the privacy and security of your health information. This information, known as "protected health information" or "PHI," includes data that can be used to identify you and that the Plan has created or received about your past, present or future health or condition, the provision of health care to you, or the payment for this health care. HIPAA requires the Plan to provide you with this notice about the Plan's legal duties and privacy practices with respect to your PHI and to notify affected individuals following a breach of unsecured PHI.

The Plan must follow the terms and conditions of this notice as long as it is in effect. However, the Plan reserves the right to change the terms and conditions of this notice at any time. Any changes will apply to the PHI that the Plan already has. If the Plan materially changes this notice, a revised notice will be sent to you by regular mail or by e-mail, if you have agreed to receive amended versions of this notice electronically. You can also request a copy of this notice by writing to the address listed in Section VIII of this notice at any time and you can view a copy of this notice, as amended, on the Transform Web site at **www.88sears.com**. Except when required by law, the Plan will not implement a material change to any term of this notice prior to the effective date of the new notice, which includes the material change.

This notice does not apply to the PHI used and maintained by any insured benefit program or option. If you have coverage through an insured benefit program or option, you will receive a separate notice from the insurer.

For purposes of this notice, capitalized terms shall have the meaning as such terms are defined in HIPAA, the Privacy Rule, the Transaction Rule or the Security Rule, as applicable all as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act").

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The Plan uses and discloses PHI for many different reasons. The Plan will share PHI with each other as necessary to carry out treatment, payment or health care operations relating to the Plan. With some exceptions, they may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. Described below are the different categories of the Plan's uses and disclosures, along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

With limited exceptions, the Plan may use or disclose your PHI for treatment, payment, and health care operations without your authorization. Examples of these uses and disclosures include the following:

1. For treatment:

"Treatment" includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with another party. It also includes consultation between health care providers relating to a patient or the referral of a patient for health care from one health care provider to another.

The Plan does not provide treatment. However, from time to time it may need to use or disclose your PHI for treatment purposes. For example, prior to providing a health service to you, your doctor may ask the Plan for information concerning whether and when the service was previously provided to you. The Plan may use and disclose your PHI for treatment activities of a health care provider.

2. For payment:

The Plan uses and discloses your PHI in order to fulfill its responsibilities for providing coverage and health care benefits under the Plan or to obtain or provide reimbursement for the provision of health care. This includes the following activities:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims.
- Risk adjusting amounts due based on participant health status and demographic characteristics.
- Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing.
- Review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, or justification of charges.
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services.
- Disclosure to consumer reporting agencies of certain PHI relating to collection of premiums or reimbursement.

For example, the Plan will use your PHI in reviewing a claim submitted by you or your doctor to determine payment. It may also disclose your PHI to another carrier to determine which carrier is primary or to otherwise determine cost sharing between the Plan and the other carrier. It may disclose your PHI to a physician for his or her opinion as to whether the requested services are necessary. The Plan may also disclose your PHI to an attorney or collection agency to make a collection effort for amounts that are due to the Plan. The Plan may use and disclose your PHI to other health plans, clearinghouses or health care providers for their payment activities.

3. For Health Care Operations:

The Plan will use and disclose your PHI in performing those day-to-day administrative uses that are necessary for them to act as your health benefits program. The Plan's health care operations include the following activities:

- Conducting quality assessment and improvement activities, as well as population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and performing related functions that do not include treatment.
- Reviewing the qualifications and performance of health care providers, evaluating health plan performance, training, and performing accreditation, certification, or licensing activities.
- Performing underwriting, premium rating, and other activities relating to the creation, renewal or replacement of health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Business planning and development.
- Managing Plan business and performing general administrative activities.

For example, the Plan needs to use your PHI along with that of other participants for purposes of establishing budgets. Or, if you have a complaint about a provider or with the Plan, the Plan may, in order to resolve matters, need to review your file, which may contain relevant PHI. The Plan also may need to review your PHI for purposes of conducting programs to curb provider fraud. It may disclose your PHI to other health plans, health care clearinghouses or health care providers covered under HIPAA for their health care operations provided that the other entity has (or had) a relationship with you, the PHI that the Plan discloses pertains to that relationship, and the disclosure is for limited health care operations described in the first two items listed above (quality assurance, reviewing qualifications and performance) or for fraud and abuse detection or compliance.

The Plan will not use or disclose PHI that is genetic information of an individual for underwriting purposes.

B. Other Purposes for Which the Plan is Permitted or Required to Use or Disclose Your Protected Health Information Without Your Written Authorization.

The Plan may also use and disclose your PHI without authorization for the following reasons:

1. **When a disclosure is required by federal, state or local law.** For example, the Plan makes disclosures when a law requires that they report information to government agencies.
2. **In the course of judicial or administrative proceedings.** For example, the Plan may disclose information pursuant to a court order.
3. **For law enforcement purposes.** For example, the Plan may disclose information in response to a law enforcement official's request for such information to

identify or locate a suspect, material witness or missing person.

4. **For public health activities.** For example, the Plan may report information about the safety or effectiveness of an FDA-regulated product or activity or information about various diseases to government officials in charge of collecting that information.
5. **To report incidents of abuse, neglect or domestic violence.** If the Plan's Associates suspect abuse, neglect or domestic violence, the Plan may provide information to appropriate authorities.
6. **For health oversight activities.** For example, the Plan will provide information to assist the government when it conducts an investigation of a health care plan or provider.
7. **For research purposes.** In certain circumstances, the Plan may provide PHI in order to conduct medical research.
8. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, the Plan may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
9. **For specific government functions.** The Plan may disclose PHI of military personnel and veterans in certain situations. And they may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
10. **For workers' compensation purposes.** The Plan may provide PHI in order to comply with workers' compensation laws.
11. **Appointment reminders and health-related benefits or services.** The Plan may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits.
12. **To Vendors.** There are some services provided to the Plan through various vendors. Examples include the third-party administrators that the Plan engages to process payment of your health claims. (Information regarding where to find a complete list of these vendors is set forth in Section VII of this notice.) The Plan may disclose your PHI to these vendors so that they can perform the services the Plan has contracted with them to perform. To protect your PHI, however, the Plan requires that the vendors appropriately safeguard your information.
13. **To Limited Data Set Recipients.** The Plan may make available to another individual or entity your PHI in a "limited data set" for purposes of research, public health and health care operations. A limited data set is PHI that excludes direct identifiers of you or your relatives, employers, or household members. To protect your PHI, the Plan requires that the recipient of the limited data set appropriately safeguard your information.
14. **Incidental Disclosures**. The Plan may use or disclose your PHI incidentally as part of another use or disclosure that is permitted under law.

C. Marketing.

We will need your written authorization to use and disclose your PHI for marketing purposes, except if the marketing is a face-to-face communication or if it involves a promotional gift of nominal value. "Marketing" includes a communication about a product or service that encourages you to purchase or use the product or service. It also includes an arrangement whereby the Plan discloses your PHI to another entity, in exchange for compensation, and the other entity communicates about its own product or service to encourage purchase or use of that product or service. Marketing does *not* include a description of a health-related product or service (or payment for such product or service) that the Plan provides or includes in its benefits. For example, the Plan may communicate to you (without your authorization) about the Plan's provider network, replacement of, or enhancements to, the health programs, and health-related products or services available only to plan participants that add value to, but are not part of the plan of benefits. Marketing also does *not* include the Plan's communication for your treatment or for case management or care coordination purposes, or to recommend to you alternative treatments, therapies, health care providers, or settings of care.

D. Disclosures of your Protected Health Information to Transform, the Sponsor of Your Plan.

Transform may ask the Plan to provide your PHI to it. The Plan will provide the PHI unless it is prohibited by law from doing so. In most cases, the Plan will disclose your PHI to Transform only to the extent necessary to carry out plan administration functions. The Plan will not disclose your PHI to Transform for the purpose of employment-related actions or decisions or in connection with any other benefit or Associate benefit program of Transform.

E. Uses and Disclosures for Which You Have the Opportunity to Object.

The Plan may use or disclose your PHI to: (1) a family member, friend, or other person that you indicate is involved in your care or the payment for your health care; (2) notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care regarding your location, general condition, or death; or (3) a disaster relief organization for purposes listed in (2) above. In all of these cases, the Plan may do so unless you object in whole or in part. If you are not present or in the event of your incapacity or an emergency, the Plan will, in the exercise of their professional judgment, determine if the disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your health care. However, in an emergency, the Plan may use and disclose your PHI without approval for notification purposes to disaster relief organizations.

F. All Other Uses and Disclosures of Your Protected Health Information Require Your Written Authorization.

Uses and disclosures of your protected health information for purposes other than those referred to above will be made only with your written authorization. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that the Plan has not taken any action relying on the authorization). Notwithstanding any provision of this Notice, the Plan will obtain a written authorization for the following:

- Any use or disclosure of psychotherapy notes, except: (1) To carry out the following treatment, payment, or health care operations: Use by the originator of the psychotherapy notes for treatment; Use or disclosure by the Plan for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or Use or disclosure by the Plan to defend itself in a legal action or other proceeding brought by the individual; and (2) A use or disclosure that is: required by the Secretary of the United States Department of Health and Human Services ("HHS") when the Secretary is investigating or determining the Plan's compliance with the Privacy Rule; permitted by law; for health oversight with respect to the oversight of the originator of the psychotherapy notes; to a coroner or medical examiner for the purpose of identifying a decedent; or to avert a serious threat to health or safety.
- Any use or disclosure of PHI for marketing, except if the communication is in the form of: a face-to-face communication made by the Plan to an individual, or a promotional gift of nominal value provided by the Plan. If the marketing involves financial remuneration to the Plan from a third party, the authorization must state that such remuneration is involved.
- Any disclosure of PHI which is a sale of PHI. Such authorization must state that the disclosure will result in remuneration to the Plan.

G. Additional State and Federal Law Requirements.

State laws of general applicability which have criminal penalties, as well as some federal laws, may further limit the Plan's use and disclosure of your PHI. For example, state law may require that the Plan obtain your written permission to use and disclose your PHI even though written authorization would not otherwise be required under this notice. The Plan will abide by applicable state and federal law.

H. If Your PHI is Improperly Disclosed.

Your PHI may or may not be encrypted when it is held by a vendor. If it is not encrypted and is improperly disclosed in a way that poses a significant risk to you, the vendor will notify you promptly upon learning of the problem in full compliance with federal law. This notice will explain to you what type of information was involved, what happened to the PHI, what the vendor is doing to fix the problem and mitigate any potential harm, and what steps you can take to protect yourself. You will also receive any notice that may be required under a state law.

I. Protection of Your Electronic Health Information

With respect to electronic PHI, the Plan Sponsor: (i) has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan; (ii) ensures that the adequate separation required by federal law is supported by reasonable and appropriate security measures; (iii) ensures that any agent, including a subcontractor, to whom the Plan Sponsor provides such information agrees to implement reasonable and appropriate safeguards to protect the information; and (iv) reports to the Plan any Security Incident of which the Plan Sponsor becomes aware.

J. Breaches of Unsecured Protected Health Information

In the event of a breach of your PHI, the Plan Administrator (or its designee) shall comply with the notification duties under federal law.

You will be notified in writing that your PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of a breach without unreasonable delay and in no case later than 60 calendar days after discovery of such breach. The notice will include: (i) a brief description of what happened, including the date of the discovery of the breach, if known; (ii) a description of the types of unsecured PHI that were involved with the breach (i.e. full name, social security number, date of birth) (iii) any steps you should take to protect yourself from potential harm resulting from the breach; (iv) a brief description of what the Plan Administrator is doing to investigate the breach, to mitigate harm to you and to protect against any further breaches; and (v) contact procedures for you to ask questions or learn additional information, which shall include a toll-free telephone number, and e-mail address, web-site, or postal address.

If a breach involves more than 500 residents of a State or jurisdiction, the Plan Administrator shall, following the discovery of a breach, notify prominent media outlets serving the State or jurisdiction without unreasonable delay, but in no case later than 60 days after the discovery of a breach. The Plan Administrator shall also notify the Secretary of HHS in accordance with HHS requirements.

Separately, State law may provide greater protections or notification requirements than those described here.

K. Sale of Your Protected Health Information

Except as permitted under federal law, the Plan shall not directly or indirectly receive remuneration in exchange for PHI.

L. Business Associate Agreements

If an entity acts as a Business Associate of the Plan, the Plan and such Business Associate shall execute a contract that meets the requirements under federal law for such agreements.

III. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights described below with respect to PHI held by the Plan's vendors (information regarding where to find a complete list of these vendors is set forth in Section VII of this notice).

A. The Right to Choose How PHI is Sent to You.

You have the right to ask each vendor to send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate means (for example, e-mail instead of regular mail). The vendors are required to accommodate reasonable requests if you inform such vendor that to provide the information otherwise would put you in danger.

B. The Right to Get This Notice by Paper Copy.

If we send you this notice via e-mail, you have the right to request a paper copy.

C. The Right to Amend Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request the vendor in possession of the information to correct the existing information or to add the missing information. You must provide the request and your reason for the request in writing to the vendor that you believe has the incorrect information (hereinafter referred to as the "Request For Amendment"). The vendor may have prepared forms to assist you in this process. The vendor will respond within 60 days of receiving your request. If your request is denied, the written denial you receive will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a statement of disagreement, you have the right to request that your written request and the denial be attached to all future disclosures of that PHI.

If a vendor approves your Request For an Amendment, the vendor must report the amendment of PHI to other vendors of the Plan that the vendor's agents reasonably believe possess the unamended PHI and to persons or entities that you identify in your Request For Amendment. (In your Request For Amendment, you may provide a list of individuals or entities that you believe possess the unamended PHI and either the vendor or the Plan will use its best efforts to contact such individuals and entities regarding the amendment.)

D. The Right to Request Limits on Uses and Disclosures of Your PHI.

You have the right to ask a vendor to restrict the use and disclosure of your PHI for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask a vendor to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask a vendor to restrict use and disclosure of PHI to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the vendor must be in writing.

Except as provided in the next paragraph, a vendor is not required to agree to a requested restriction. If a vendor does agree, a restriction may later be terminated by your written request, by agreement between you and the vendor (including an oral agreement), or unilaterally by the vendor for PHI created or received after you're notified that the vendor has removed the restrictions. The vendor may also disclose PHI about you if you need emergency treatment, even if the vendor has agreed to a restriction.

A vendor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

E. The Right to Access Your PHI.

In most cases, you have the right to view or obtain copies of your PHI on file with each vendor, but you must make the request in writing to each vendor. If the vendor that you contact does not have your PHI but is aware of a vendor that does, it will redirect you to the appropriate vendor or to the Plan. A vendor will respond to you within 30 days after receiving your written request. In certain situations, a vendor may deny your request. If so, the vendor will notify you, in writing, of the reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, the vendor may charge a fee. Instead of providing the PHI you requested, the vendor may provide you with a summary explanation of the PHI as long as you agree to the summary and to the costs associated with the summary in advance.

F. The Right to an Accounting of Disclosures of Your PHI.

You have the right to get a list of instances in which each vendor has disclosed your PHI (hereinafter sometimes referred to as an "accounting"). The list will not include uses or disclosures: (i) made to you, (ii) made for treatment, payment, or health care operations, (iii) made pursuant to an authorization, (iv) which are incidental, or (v) for which you have the right to object (and you did not object). The list also will not include uses and disclosures: (a) made for national security purposes, (b) made to corrections or law enforcement personnel, (c)

made as part of a limited data set, or (d) which were made before April 14, 2003. Each vendor will respond within 60 days of receiving your request. The list provided will include disclosures made in the last six years, unless you request a shorter time frame. The list will also include the date of the disclosure, to whom PHI was disclosed (including contact information, if available), a brief description of the information disclosed, and the purpose for the disclosure. A vendor may impose fees for such service.

When exercising your right to receive access to your PHI, to request an accounting of the use and disclosure of your PHI, or to limit the uses and disclosures of your PHI, you must separately contact each vendor of the Plan that may have the relevant PHI and request the appropriate action. If you are unsure as to which vendors to contact or to whom to make a request, you may write to the Transform HIPAA Privacy Official at the address listed in Section VIII of this notice. Any such access, accounting, or limitations on your PHI will only be effective as to those vendors that you contact. If, for example, you wish to limit the use or disclosure of your PHI, you may wish to separately request such a limitation from each vendor that may possess such information. A vendor will assist you in exercising your rights according to its policies and procedures and the policies and procedures of the Plan that govern the responsibilities of a vendor. For this purpose Transform is treated as a vendor to the extent that it uses or discloses PHI for Plan administration.

IV. IF YOU HAVE COMPLAINTS

If you think that the Plan or one of its vendors may have violated your privacy rights, you may file a written complaint by sending it to the address listed in Section VIII of this notice. You also may send a written complaint to the Secretary of HHS. The Plan will take no retaliatory action against you if you file a complaint about their privacy practices.

V. VENDORS

To accommodate the administrative needs of their vendors, the Plan has agreed to adopt, when available, the policies and procedures of each of their vendors with respect to PHI used or disclosed by that vendor in connection with the services it renders to the Plan. If a vendor does not adopt appropriate policies and procedures regarding your rights with respect to your PHI, the Plan will adopt appropriate policies and procedures for use by that vendor.

VI. CONTACTING PLAN VENDORS

Accompanying this Notice is a list of the Plan's vendors. Updates to this list (if any) may be found at the Transform Web site at **www.88sears.com**. If, upon contacting the vendors at the locations listed, you are unable to exercise your privacy rights as set forth in Section IV of this notice, you may write to the Transform HIPAA Privacy Official at the address listed in Section VIII of this notice.

VII. WHO TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about the Plan's privacy practices, or would like to know how to file a complaint with the Secretary of HHS, please write to the Transform HIPAA Privacy Official at the following address:

Transform Midco LLC
HIPAA Privacy Official
5407 Trillium Boulevard Suite B120
Benefits Department
Hoffman Estates, IL 60192
Phone: **248-463-7900**

Transform Health and Welfare Plan Vendor Contact Information		**May have PHI that participants have the Right to:**		
Transform Group Health Plan(s)	Vendor Contact Information	Access	Amend	Account For
Medical Program	Businessolver 1025 Ashworth Rd West Des Moines, IA 50265 Company Support Phone: 888-887-3277, option 1 7:00 a.m. - 7:00 p.m. CST, Monday-Friday BCBSIL Basic (HDHP), Enhanced (PPO), and BlueHPN Options: Blue Cross Blue Shield of Illinois BCBSIL P.O. Box 805107 Chicago, IL 60680-4112 **1-855-547-1393** **www.bcbsil.com/transform** Prescription Drug Coverage under BCBSIL Options: Express Script Pharmacy – Manual Claims PO Box 29044 Hot Springs, AR 71903 **1-844-368-8771**	✓	✓	✓
Health Care Flexible Spending Accounts	MyChoice Accounts MSC 345475 P.O. Box 105168 Atlanta, GA 30348-5168 Fax 855-883-8542 Email: claims@mychoiceaccounts.com Fax: 1-847-554-5134 Phone: **1-888-887-3277, option 1** (follow path to health and group benefits) 7:00 a.m. - 7:00 p.m. CST, Monday-Friday My Choice Accounts PO Box 7105 Rantol, IL 61866-7105 **1-888-887-3277, option 1**	✓	✓	✓
Associate Assistance Program	Aetna Resources for Living 4300 Centerway Place Arlington, TX 76018 **1-800-424-4732**	✓	✓	✓

Other Support Vendors to Transform Group Health Plan		**May have PHI that participants have the Right to:**		
Vendor Contact Information	Description of Services	Access	Amend	Account For

Businessolver 1025 Ashworth Rd West Des Moines, IA 50265 Company Support Phone: 888-887-3277, option 1 7:00 a.m. - 7:00 p.m. CST, Monday-Friday	Performs services such as annual enrollment processing, initial eligibility claims administration and COBRA administration.	✓	✓	✓
Transform Midco LLC (acting through its Associates as HIPAA Privacy Official and Plan Administrator) 5407 Trillium Boulevard Suite B120 Benefits Department Hoffman Estates, IL 60192 Phone: **248-463-7900**	Oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to Transform health plans policies and procedures covering the privacy of, and access to, protected health information.			✓

IMPORTANT NOTICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Please read this notice carefully. This notice has information about the current prescription drug coverage options offered through the Transform Medical Program 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 Part D plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

Medicare prescription drug coverage became available in 2006 to everyone eligible for Medicare. You can get this coverage if you join a private Medicare Prescription Drug Plan or 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.

CREDITABLE HEALTH PLANS

Transform has determined that the prescription drug programs offered under the Medical Program are **"CREDITABLE,"** meaning that on average, for all plan participants, those programs are expected to pay out at least as much as the standard Medicare Part D coverage pays.

DECISIONS YOU NEED TO MAKE

If you are enrolled in the Transform Medical Program, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully - it explains your options.

If you are enrolled in the Transform Medical Program with prescription coverage, then your coverage is, on average, at least as good as standard Medicare prescription drug coverage. You do not need to enroll in a Medicare drug plan, and you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will also be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Part D plan. *In addition, if you lose or decide to leave Transform sponsored coverage you will be eligible to join a Part D plan at that time using a Special Enrollment Period.* You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs for Medicare.

If you decide to join a Medicare drug plan, your Transform prescription drug coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You also should know that if you drop or lose your coverage with Transform and **do not** 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 prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly

premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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

If you have questions about this notice, call the Transform Benefits Center at **1-888-887-3277, option 1** (select the option for medical). You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan. You also may request a copy at any time.

If you have questions about your current Transform health care coverage, visit **www.88sears.com** or call the Transform Benefits Center at **1-888-887-3277, option 1** (select the option for medical).

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

Detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" booklet. You will receive a copy of this booklet in the mail every year from Medicare. You may also be contacted directly by individual Medicare drug plans within your state.

For more information about Medicare prescription drug coverage:

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

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

STATEMENT OF ERISA RIGHTS

As a participant in the Plan described in this Handbook that are ERISA plans, you are entitled to certain rights and protections under ERISA with respect to the ERISA benefits.

ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Associate Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Medical Program, Dental Program, Vision Program or Health Care FSA as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Coverage for yourself, spouse or dependents continues for 36 months if there is a loss of coverage under the EAP as a result of a termination of employment.

PRUDENT ACTIONS OF PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Associate benefit plan. These people are called "fiduciaries" and have a duty to operate the plans prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court subsequent to exhausting the plan's claims procedures, provided that a suit is filed within six months of the date you received or were deemed to receive an adverse determination of a final claim appeal (refer to the "Claims Information" section above). 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the plan's claims procedures (refer to the "Claims Information" section above). In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Associate Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Associate 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 Associate Benefits Security Administration.