CAUTION: This document is a sample and is intended to be used as a starting point for creating a wrap summary plan description for a fully insured health plan. It requires extensive customization before it can be used. The plan administrator should review any final draft of this document before use to confirm its accuracy, and consulting with legal counsel and the insurance company is recommended. Failure to properly review this document may result in additional or unintended liability for the health plan and/or plan sponsor. Any such liability is the sole responsibility of the plan sponsor.

HEALTH PLAN SUMMARY PLAN DESCRIPTION

1. INTRODUCTION

[Insert Company Name] (the Company) maintains this group health plan (the Plan) to provide benefits to you and your eligible dependents. Your benefits are provided under an insurance contract between the Company and [Insert Insurer Name] (the Insurer).

This document and the attached certificate of insurance booklet from the Insurer make up your summary plan description (SPD). Please read this document and the attached booklet to learn about your health plan benefits. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information. Please keep your health plan documents in a safe place for future reference.

Please note that this document does not provide any substantive rights to benefits that are not included in the attached certificate of insurance booklet.

If you have any questions regarding the Plan, including whether you are eligible to participate in the Plan, please contact the Company. If you have questions regarding benefits payable under the Plan, please contact the Insurer.

2. PLAN INFORMATION

Name of Plan:

[Insert Name of Plan, for example, ABC Company Group Health Plan]

Type of Plan:

Group health plan

Policy Number:

[Insert Plan's Policy Number with Insurer]

Plan Sponsor:

[Insert Company Name]

Plan Administrator:

[Insert Company Name]

Agent for Service of Legal Process on the Plan:

[Insert Company Name]

[Insert Company Street Address]

[Insert Company City State Zip Code]

Legal process can be served on the plan administrator.

Insurance Company:

[Insert Insurer Name and Address]

Identification Numbers:

1. Plan Sponsor's Employer Identification Number (EIN): [Insert Company EIN]

2. Plan Number: [Insert Plan Number]

Plan Year:

January 1 through December 31

Effective Date:

The effective date of the Plan is [insert date of last renewal]. The original effective date was [insert original effective date]. The Plan has been amended since the original effective date.

IMPORTANT DISCLAIMERS

Conflicting Terms

If the terms of this document conflict with the terms of the insurance contract between the Company and the Insurer, the insurance contract will control. This document may not confer additional rights that are not contained in the insurance contract.

Grandfathered Status [IF APPLICABLE]

The Company believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans

must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Company or any other arrangement indicating that you will be employed for any specific period of time.

3. FUNDING AND ADMINISTRATION

Funding

The Plan is fully insured. Plan benefits are payable pursuant to a contract with the Insurer. Claims for benefits are sent to the Insurer and the Insurer is responsible for paying benefits. The Company is not responsible for paying benefits under the Plan.

Premium contributions are paid in part by the Company out of its general assets and in part by employees through pre-tax contributions. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract entered into between the Company and the Insurer will be allocated, if consistent with the fiduciary obligations imposed by ERISA and permitted by law, to reimburse the Company for premiums that it has paid.

Type of Administration

Because the Plan's benefits are provided through an insurance contract, both the Insurer and the Company administer the Plan.

The Company, as plan administrator, has the discretionary authority to interpret and administer the Plan. This includes making determinations of an individual's eligibility to participate in the Plan. The Insurer has the authority to make benefit determinations under the Plan and is the Named Fiduciary responsible for following the Plan's claims procedures.

Compliance with State and Federal Laws

To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of

1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (PPACA).

Amendment or Termination

The Company may modify, amend or terminate the Plan at any time at its sole discretion. The right to modify, amend or terminate also applies to the insurance contract between the Company and the Insurer. Any modification, amendment, or termination will be communicated to participants under the Plan.

4. ELIGIBILITY AND PARTICIPATION

Eligibility and Enrollment

To be eligible to participate in the Plan, you must meet certain requirements. [Insert description of plan's eligibility, participation and enrollment rules, including coverage available for spouses and dependents and any waiting periods and enrollment periods]. You must pay a certain amount of the premium for coverage.

Coverage will be extended to your non-custodial child if required by a Qualified Medical Child Support Order (QMCSO). Please contact [insert contact name] at the Company for more information on the Plan's procedures for determining whether a medical child support order qualifies as a QMCSO.

Your coverage terminates on [the day/last day of the month in which/specify if other] you terminate employment with the Company. Coverage may also terminate in other circumstances, such as failure to pay required premiums, failing to meet eligibility requirements, submitting fraudulent claims and other reasons described in the attached certificate of coverage booklet. Coverage for your spouse and dependents terminates when your coverage ends and for other reasons described in the attached certificate of coverage booklet, such as divorce or reaching the Plan's limiting age for dependents.

[The following section, "Look-back Measurement Method for Eligibility Determinations," is optional. It applies to applicable large employers (ALEs) that use the look-back measurement method to determine employees' full-time status under the Affordable Care Act's employer shared responsibility rules.]

Look-back Measurement Method for Eligibility Determinations

Effective [insert date], the Company uses the look-back measurement method to determine who is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) guidance under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Company employees. *[If the look-back measurement method will only apply to certain groups of employees, revise the preceding sentence to describe which*

groups it will apply to, and note that other groups of employees will be subject to monthly measurement].

The look-back measurement method involves three different periods:

- A **measurement period** for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full-time.

    - If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your Plan eligibility for the stability period that follows the measurement period and any administrative period.

      [Optional—Include the following sentence to provide more detail on the length of the standard measurement period (SMP). If the SMP is shorter than 12 months, include all the SMP start and end dates during the year.] The SMP starts on [insert date] and ends on [insert date].

    - If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your Plan eligibility for the stability period that follows the measurement period and any administrative period.

      [Optional—Include the following sentence to provide more detail on when the initial measurement period (IMP) begins and how long it lasts.] The initial measurement period starts on [insert date] and lasts for [insert how long IMP lasts].

    - If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for Plan coverage based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

- A **stability period** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

  [Optional—Include the following sentence to provide more information on the length of the stability period.] The stability period [insert description of how long the stability period lasts].

- An **administrative period** is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment.

  [Optional—Include the following sentence to provide more information on the length of the administrative period.] The administrative period lasts [insert length of administrative period].

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from an unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is just a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact [insert contact information].

[The following section, "Monthly Measurement Method for Eligibility Determinations," is optional. It applies to ALEs that use the monthly measurement method to determine employees' full-time status under the Affordable Care Act's employer shared responsibility rules.]

Monthly Measurement Method for Eligibility Determinations

Effective [insert date], the Company uses the monthly measurement method to determine who is a full-time employee for purposes of Plan coverage. The monthly measurement method is based on Internal Revenue Service (IRS) guidance under the Affordable Care Act (ACA).

The monthly measurement method applies to all Company employees. *[If the monthly measurement method will only apply to certain groups of employees, revise the preceding sentence to describe which groups it will apply to, and note that other groups of employees will be subject to the look-back measurement method].*

The monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. In general, an employee will be treated as full-time for any month in which he or she averages at least 30 hours of service per week (or 130 hours of service in a calendar month). An employee will generally be ineligible for the Plan's health care benefits for any month in which he or she averages less than 30 hours of service per week (or 130 hours per calendar month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The Company intends to follow applicable IRS guidance when administering the monthly measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Special Enrollment Rights

In certain special circumstances, you and/or your dependents may enroll in the Plan at times other than open enrollment. The attached certificate of insurance booklet and the Plan's Special Enrollment Notice contain more information about potential special enrollment rights.

Continuation of Coverage

If your coverage or the coverage of your spouse or dependents terminates because of certain reasons known as qualifying events (such as termination of employment, reduction in hours, divorce, death, or child ceasing to be a dependent under the plan), you, your spouse and your dependents may be entitled to continue health care coverage for a certain period of time under a federal law called COBRA. In addition, if you are absent from employment due to military service, you may be entitled to continuation of coverage or reinstatement in the Plan under a federal law called USERRA. You or your dependents may have to pay for such coverage. Contact [insert contact name] at the Company for more information about your rights under COBRA and/or USERRA.

5. PLAN BENEFITS

The Plan provides benefits to you and your eligible spouse and dependents while you are eligible for and covered by the Plan. For a detailed description of benefits available under the Plan, please review the attached certificate of insurance booklet. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information.

Benefits are no longer payable if your coverage is terminated for any reason. The Plan reserves the right to recover overpayments of benefits or benefits paid in error through the rights of subrogation and reimbursement as described more fully in the attached certificate of insurance booklet.

Please review the attached certificate of insurance booklet carefully for information on other situations that may affect your right to receive benefits under the Plan, such as applicable deadlines for submitting claims.

Newborns' and Mothers' Health Protection Act

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

authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your plan administrator at [insert phone number].

Notice of Patient Protections *[Include the following disclosure, as applicable, for health plans that require designation of a primary care provider.]*

The Plan generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. *[If the plan or health insurance coverage designates a primary care provider automatically, insert:* Until you make this designation, the Plan designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [Company/Insurer] at [insert contact information].

[For plans and issuers that require or allow for the designation of a primary care provider for a child, add:]

For children, you may designate a pediatrician as the primary care provider.

[For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:]

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

health care professionals who specialize in obstetrics or gynecology, contact the [Company/Insurer] at [insert contact information].

6. CLAIMS PROCEDURES

Benefit Claims and Appeals

The Insurer is responsible for reviewing and deciding all benefit claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The attached certificate of insurance booklet provides more information about the Insurer's claims procedures, including information on how to file a claim.

Claim Appeals

The Insurer may deny claims in part or in full pursuant to the terms of the Plan. If your claim is denied, you will be notified of the denial. You may appeal any denial of a claim. The Insurer will review your denied claim and will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law.

If you do not appeal a denial by the applicable deadlines, you will lose certain rights, such as the right to file a lawsuit regarding the denial and you will not be deemed to have exhausted your internal administrative rights.

In some cases, you may have the right to an external review, which consists of review by an independent third party. The attached certificate of insurance booklet provides more information about external review.

7. STATEMENT OF ERISA RIGHTS

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). 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 Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide 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 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. 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 Employee Benefits

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