PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

LIBERTY UTILITIES

HEALTH AND WELFARE BENEFIT PLAN FOR ACTIVE EMPLOYEES

(Plan No. 501)

January 2023

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ARTICLE I
ESTABLISHMENT AND PURPOSE OF THE PLAN

The group welfare benefit plan set forth in this document (the "Plan") is sponsored and maintained by the Plan Sponsor for the purpose of combining into a single legal plan document the various Benefit Programs made available to eligible employees of the Plan Sponsor and its participating affiliates. The Plan was originally established effective as of January 1, 2012. This Plan document amends and restates the prior Plan document in its entirety and is effective January 1, 2023.

This Plan is intended to meet all applicable requirements of Employee Retirement Income Security Act of 1974, as amended (ERISA) and, together with the summary plan booklets for the underlying Benefit Programs, is also intended to constitute the summary plan description (or SPD) for the Plan.

Notwithstanding the number and types of benefits incorporated by reference under this Plan document, the Plan is and will be treated as a single benefit plan to the extent permitted under ERISA. In the event that the provisions of any Benefit Program conflict with the provisions of this document or any other Benefit Program, the Plan Administrator will interpret the terms and purpose of the Plan to resolve any conflict. However, the terms of this Plan document may not increase the rights of a participant or his or her beneficiary in any manner, including but not limited to benefits available under any Benefit Program.

ARTICLE II
GENERAL INFORMATION

Name of Plan	Liberty Utilities Health and Welfare Benefit Plan for Active Employees
Plan Number	501
Plan Sponsor	Liberty Utilities Co. Attention: Benefit Plans Administrative Committee 14920 W. Camelback Road Litchfield Park, AZ 85340
Employer Federal Identification Number	EIN: 27-4444001
ERISA Plan Administrator	Liberty Utilities Co. Attention: Benefit Plans Administrative Committee 14920 W. Camelback Road Litchfield Park, AZ 85340 Telephone: 905-465-4500
Type of Plan	Welfare Benefit Plan
Type of Administration	Some benefits under the Plan may be uninsured and paid from the general assets of the employer. In certain cases, the employer has entered into contracts with third party vendors for the purpose of assisting the employer in administering self-

	funded benefits. Other benefits under the plan may be fully insured and paid pursuant to the terms of an insurance policy issued by an insurance company. Employee contributions and/or premiums for coverage are paid through payroll deduction. A complete list of the benefits which are paid on a self-funded or fully insured basis is available from the Plan Administrator upon request.
Plan Year	Calendar Year
Agent for Service of Legal Process	Liberty Utilities Co. Attention: General Counsel 14920 W. Camelback Road Litchfield Park, AZ 85340
Participating Employers	Liberty Utilities Service Corp. Liberty Utilities Park Water Corp Liberty Utilities Apple Valley Ranchos Water Corp Liberty Utilities (St. Lawrence Gas) Corporation Liberty Utilities (St. Lawrence Gas) Service & Merchandising Corp. Liberty Utilities Calpeco Electric LLC Liberty Utilities (New York Water) Corp. Algonquin Power Fund America Inc. Empire District Electric Co The participating employers may change from time to time. You may contact the Plan Administrator for an updated list of participating employers.

ARTICLE III
DEFINITIONS

The following terms, whether or not capitalized, have the meaning set forth below unless the context plainly requires a different meaning:

"Benefit Program" means each benefit program identified in Appendix A, as updated from time to time, attached to this Plan. The terms and coverage of each Benefit Program are set forth in a separate contract, document or SPD, but form a part of this Plan in the same manner as if all the terms and provisions of such separate contract or other document were included in this Plan document. To the extent a separate contract, document or SPD incorporated herein by reference is written in a manner to apply to active employees and retirees, only those provisions of such contract, document or SPD applicable to active employees shall be interpreted and administered as comprising a part of this Plan.

"Claims Supervisor" means the person or entity responsible for benefits administration under a Benefit Program. In the case of an insured Benefit Program, the Claims Supervisor means the insurance carrier.

"Eligible Employee" means each current or future person whose relationship to his or her Employer is classified by the Employer as that of a common law employee. The Employer's employment classification of an employee will be binding and controlling on all parties and will continue in effect regardless of any contrary classification or reclassification of such person by any other person or entity including, but not limited to, the Internal Revenue Service, the Department of Labor, or a court of competent jurisdiction. Notwithstanding any provision in this Plan to the contrary, the following individuals shall be excluded from participating in the Plan: any leased employee as defined in section 414(n)(2) of the U.S. Internal Revenue Code; any employee who is part of a collective bargaining unit unless the Employer and the representative for the collective bargaining unit have agreed to participation under this Plan or a Benefit Program; any person whose relationship with the Employer is deemed by the Employer not to be that of a common law employee; or any employee classified as a seasonal or temporary worker.

"Employee Contribution" means the pre-tax or after-tax contribution required to be paid by or on behalf of an Eligible Employee or beneficiary, as determined under each Benefit Program. The term "Employee Contribution" includes contributions used for the provision of benefits under a self-insured arrangement as well as contributions used to pay premiums under an insurance policy.

"Employer" means and includes the Plan Sponsor and any other Related Employer which participates in the Plan with respect to its employees.

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

"Plan" means this plan document and each Benefit Program which is included as part of this Plan, each as amended from time to time.

"Plan Administrator" means the Plan Sponsor or any person or committee appointed by the Plan Sponsor to administer the Plan. In the absence of such appointment, the Plan Sponsor will serve as the formal plan administrator within the meaning of ERISA. The Plan Administrator is the "named fiduciary" of the Plan, as defined in section 402(a)(2) of ERISA.

"Plan Sponsor" means Liberty Utilities Co.

"Plan Year" means the calendar year. The underlying Benefit Programs need not be administered on a Plan Year basis.

"Related Employer" means Liberty Utilities Service Corp. and any other entity that is a member of the Plans Sponsor's controlled group, as defined in sections 414(b), (c), (m) and (o) of the U.S. Internal Revenue Code. The Plan Sponsor has the sole discretion to determine the Related Employers which are eligible to participate in the Plan.

ARTICLE IV
ELIGIBILITY AND PARTICIPATION

4.1 Eligibility. Each active Eligible Employee will become a participant in the Plan when he or she satisfies the eligibility and participation requirements of any Benefit Program. Coverage may also be available for the Eligible Employee's spouse, domestic partner and dependent children.

4.2 Termination of Participation. Participation under the Plan will cease when the Eligible Employee ceases to satisfy the eligibility requirements under all of the Benefit Programs.

4.3 Participant Cooperation. Circumstances may arise in which the Employer or the Plan Administrator may require a participant or beneficiary to furnish information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from a Benefit Program, including, but not limited to, information for the Employer to pursue a reinsurance or stop loss insurance claim, or information related to a recovery under the Subrogation and Reimbursement provisions under Article VII below. Each participant or beneficiary, in consideration of the coverage provided by such Benefit Program, must fully cooperate, provide any and all information requested, execute any and all documents that will enable the Employer or the Plan Administrator to access such information, and pay any amount due pursuant to a Benefit Program. In the event a participant or beneficiary fails to comply with this cooperation provision within the time period set by the Plan Sponsor in its sole and absolute discretion or provides false information in response to such request, payment of all benefits under the Benefit Program (whether or not such benefits relate to the requested information or failure to pay) may be suspended and/or coverage may be terminated either retroactively or prospectively in the Employer's sole discretion. In addition, the Employer or the Plan Administrator may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.

ARTICLE V
BENEFIT PROGRAMS

The Benefit Programs which comprise a part of this Plan are set forth in Appendix A to this Plan document. Appendix A may be amended from time to time, without adoption of a formal amendment, to reflect additions or deletions to various welfare benefit programs offered under this Plan. The terms and conditions of coverage and the benefits available under each Benefit Program are described in the separate contracts, documents, or SPDs for such Benefit Program. All benefits will be paid solely in the form and in the amount set forth under the Benefit Programs.

ARTICLE VI
FUNDING

The Employer will determine the amount and timing of any employee contributions or any other amounts to be paid by participants or beneficiaries, and any contributions/premiums required to be paid by the Employer. Employee Contributions will be deemed to be applied to the payment of Plan benefits and expenses first, before any Employer Contributions are so applied. Nothing in this Plan requires the Employer to contribute to or under any Benefit Program, or to maintain any fund or segregate any amount for the benefit of any participant or beneficiary, except to the extent specifically required under the terms of a Benefit Program. No participant or beneficiary will have any right to, or interest in, the assets of the Employer. To the extent an insurance carrier or other party pays any rebate, allowance, credit, settlement or other amount with respect to the Plan or an insurance policy (a "Recovery"), such Recovery will

reduce or offset Employer expenses and will not reduce, offset or be treated as being attributable to employee contributions or to any other amounts paid by participants or beneficiaries. In the event a Recovery exceeds Employer expenses (as determined by the Plan Administrator in its sole discretion), such Recovery will be retained solely by the Employer, not to exceed the amount of contributions/premiums previously made by the Employer to the Plan minus any prior Recoveries received by the Employer. Recoveries will not be considered assets of the Plan, and participants and Beneficiaries will not be eligible to share in any Recovery.

ARTICLE VII
COORDINATION OF BENEFITS

7.1 Coordination of Benefits. If a participant has coverage under this Plan as well as coverage from other plans, benefits that are received through this Plan will be coordinated with the benefits available under the other plans. The Benefit Programs will control the terms and conditions of the coordination of benefits with other plans.

7.2 Subrogation and Reimbursement. If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan has a right of recovery.

The Plan's right of recovery includes the right to be paid an amount equal to the lesser of any payment by the third party that is directly or indirectly related to the events that directly or indirectly resulted in the covered person's sickness or injury, or the Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person's right of recovery against the third party. The Plan's right of recovery extends to any right of recovery the covered person's estate, guardian or other representative may have against the third party, whether or not the recovery specifically states that it does not relate to medical or dental expenses.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The Plan's right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person's attorneys' fees and costs or other legal expenses. Any full or partial recovery by the covered person against a third party will be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

If the Plan takes legal action to enforce its reimbursement rights, the Plan will be entitled to recover its attorney's fees and costs from the covered person.

The Plan is not obligated to pay Plan benefits incurred with respect to a covered person's injury or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, will not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive in writing, the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or

savings to the Plan. The Plan's waiver of its right of recovery with respect to one claim will not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person will not constitute a waiver of its right of recovery with respect to another covered person.

A covered person or his or her estate, guardian or other representative, must notify the Plan Administrator in writing, whenever an injury or sickness arises that provides or may provide the Plan a right of recovery.

ARTICLE VIII
ADMINISTRATION AND FIDUCIARY PROVISIONS

8.1 Plan Administrator. The Plan Administrator has sole authority to control and manage the operation and administration of the Plan, and to interpret the provisions of the Plan, including but not limited to determinations regarding eligibility for participation in and coverage under the Plan or any Benefit Program and the types and amounts of benefits payable under the Plan, and to make all necessary findings of fact. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious and having no foundation.

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may employ persons to assist in fulfilling its responsibilities under the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

Notwithstanding the above, to the extent the benefits under any Benefit Program are provided under a fully insured arrangement, the insurance carrier for such program will have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by participants and beneficiaries thereunder. The insurance company will act as a named fiduciary with respect to the Benefit Program and will have the full power to interpret and apply the terms of the Benefit Program as they relate to benefits provided under the applicable insurance policy.

All Plan fiduciaries who are also employees or officers of the Plan Administrator will be fully indemnified by the Plan Sponsor and all other Employers against all liabilities, costs, and expenses (including but not limited to reasonable attorneys' fees and costs) imposed upon them in connection with any action, suit, or proceeding to which it may be a party by reason of being a Plan fiduciary and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

8.2 Benefit Program Responsibilities. Except to the extent otherwise determined by the Plan Administrator, the Claims Supervisor or other party designated to be responsible for benefits administration under a Benefit Program will be solely responsible for the operation and administration of such Benefit Program, including the determination of eligibility, participation and the type and amount of benefits, notification of claimants, payment of benefits, and record keeping. If a Benefit Program does not designate a party to perform these responsibilities, they will be performed by the Plan Administrator or its delegate under this Plan.

8.3 Fiduciary Duties and Responsibilities. Each Plan fiduciary will discharge his or her duties with respect to the Plan solely in the interest of the participants and their beneficiaries; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of

administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, will act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in exercising such authority.

Unless liability is otherwise provided under section 405 of ERISA, a fiduciary will not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE IX
CLAIMS PROCEDURES

9.1 General Claims Procedures. Except as otherwise provided under the "Health Plan Claims Procedures" provisions below, a claim for benefits under a Benefit Program will be submitted to the party designated under the claims procedure prescribed under the terms of such Benefit Program. In the event that a Benefit Program is not fully insured and: (i) does not prescribe a claims procedure for benefits that satisfies the requirements of section 503 of ERISA (if such section is applicable); (ii) the claims procedures described in the Benefit Program do not comply with applicable law; or (iii) the Plan Administrator determines that the claims procedures described in a particular Benefit Program will not apply, the applicable claims procedures described below will apply with respect to such Benefit Program that is not a group health plan (as defined in Department of Labor Regulation section 2560.503-1(m)(6)), and the claims procedures described the "Health Plan Claims Procedures" provisions below will apply to a Benefit Program that is a group health plan (as defined in Department of Labor Regulation section 2560.503-1(m)(6)):

(a) A claim will be filed in writing with the Plan Administrator in the form required by the Plan Administrator. No claim for benefits will be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Plan Administrator within the period prescribed in the applicable Benefit Program or as otherwise provided in this Plan. Unless otherwise stated in a Benefit Program, claims for benefits must be received by the Plan Administrator within 15 months of the expense being incurred. The Plan Administrator will make a decision on the claim (i) within 90 days, unless special circumstances require an extension of up to 90 additional days; (ii) within 45 days in the case of a disability claim, unless special circumstances require a first extension of up to 30 additional days and a second extension for special circumstances of up to 30 additional days (each such 30 day extension period will be tolled until the covered person responds to any information requested); or (iii) in the case of a group health plan, such shorter time frame as described under the "Health Plan Claims Procedures" provisions below. Written notice of the decision on such claim will be furnished promptly to the claimant. If no notice of denial is provided within the time periods set forth above, the claimant's claim will be deemed to have been denied. If the claim is wholly or partially denied, such written notice will:

(i) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Benefit Program documents;

(ii) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary;

(iii) describe the review procedures;

(iv) a statement informing the claimant of the right to bring a civil action under section 502(a) of ERISA; and

(v) for disability claims only, an explanation of the internal rules or criteria, and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge) and for disability claim denials based on medical necessity, experimental treatment, or other similar exclusions or limitations, an explanation of the scientific or clinical judgment used in the decisions, or a statement that an explanation will be provided free of charge upon request.

(b) A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 60 days (or 180 days in the case of a disability claim) after receipt by the claimant of written notice of the decision. Such written request for review will contain all additional information which the claimant wishes the Plan Administrator to consider.

Written notice of the decision on review will be furnished to the claimant within 60 days 45 days in the case of a disability claim) (or 120 days, (90 days in the case of a disability claim), if special circumstances warrant an extension and the Plan Administrator provides the claimant notice regarding the reason for delay) following the receipt of the request for review. The written notice of the Plan Administrator's decision will include specific reasons for the decision and will refer to the pertinent provisions of the Plan or Benefit Program on which the decision is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all information relevant to the claim, and a statement of the claimant's right to bring suit under ERISA (where applicable). Such suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within 90 days after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Benefit Program, such later date with respect to a claim arising out of that Benefit Program. For any disability claim, the notice will include a description of the voluntary appeal procedures offered by the Plan, if any, an explanation of the internal rules or criteria and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge), a statement that the claimant has a right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about voluntary alternative dispute resolution options from the Department of Labor or state regulators.

9.2 Health Plan Claims Procedures. Except as otherwise provided below, a claim for benefits under a Benefit Program that is a group health plan (as defined in Department of Labor Regulation section 2560.503-1(m)(6)) will be submitted to the party designated under the claims procedure prescribed under the terms of such Benefit Program. In the event that (i) a Benefit Program does not prescribe a claims procedure for benefits that satisfies the requirements of section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in a particular Benefit Program will not apply, the claims procedure described below will apply with respect to such Benefit Program:

(a) Pre–Service Claim Determinations. When a covered person requests a medical necessity determination prior to receiving care, the Claims Supervisor will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request the notice will

also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Supervisor will make the pre-service determination on an expedited basis. The Claims Supervisor will notify the covered person of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request to specify what information is needed. The covered person must provide the specified information to the Claims Supervisor within 48 hours after receiving the notice. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If a covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Supervisor will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

(b) Concurrent Claim Determinations. When an ongoing course of treatment has been approved for a covered person and the person desires to extend the approval, the person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Supervisor will notify the covered person of the determination within 24 hours after receiving the request.

(c) Post Service Claim Determinations. When a covered person requests a claim determination after services have been rendered, the Claims Supervisor will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will be sent to the claimant as soon as possible, but no later than 5 days after receipt of the claim, and will specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the individual responds to the notice.

(d) Notice of Adverse Determination. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of

why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

(e) Appeal of Denied Claim.

(i) First Level of Appeal. If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Supervisor. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Supervisor immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Supervisor will issue a decision on review.

The Claims Supervisor's review will be processed in accordance with the following time frames: (a) 72 hours in the case of urgent care services; (b) 15 days in the case of a pre-service or concurrent care claim; or (c) 30 days in the case of a post-service claim.

(ii) Second Level of Appeal. If, after exhausting the first level appeal with the Claims Supervisor, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Plan Sponsor. Appeals will not be considered by the Plan Sponsor unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 60 days of the Claims Supervisor's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

In the normal case, the Plan Sponsor will make a determination on the basis of the supporting file documents and written statement as submitted. However, the Plan Sponsor may require or permit submission of additional written information.

After considering all the evidence before it, the Plan Sponsor will issue a final decision on appeal.

the Plan Sponsor's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the following timeframes: (a) 72 hours in the case of urgent care services; (b) 15 days in the case of a pre-service or concurrent care claim; or (c) 30 days in the case of a post-service claim.

For either or both the first or second level of appeal, the Claims Supervisor or Sponsor, respectively, may obtain a limited extension of time if that party determines that special circumstances require an extension. The claimant will be notified in writing of

any such extension before the initial period of time expires and such notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension period is tolled until the claimant responds to any information request.

(f) Notice of Benefit Determination on Appeal. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (4) a statement describing any voluntary appeal procedures offered by the plan and any claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) a statement that a claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency. Any action under ERISA section 502(a) may be filed only after the plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Benefit Program, such later date with respect to a claim arising out of that Benefit Program.

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) Review Procedures on Appeal. In the conduct of any review, the following will apply:

(i) no deference will be afforded to the initial adverse determination;

(ii) the review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) in deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

(v) any health care professional consulted in making a medical judgment will be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) in the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, will be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

9.3 Proof of Claim and Right to Examine. As a condition of receiving a Plan benefit and as often as the Claims Administrator determines reasonably necessary, a covered person must submit such evidence as the Claims Administrator or Plan Administrator will require to determine that a claim is reimbursable under the terms of the Plan and will, if required by the Claims Administrator or Plan Administrator, submit to a paid physical examination by a Plan selected physician. The Plan Administrator will have the right and opportunity, at the Plan's expense, to have a physician examine the individual whose injury or disease is the basis of a claim when and as often as the Plan Administrator may reasonably require.

9.4 Limitation on Court Actions. A participant or beneficiary may bring a legal action with respect to a claim under this Plan or any Benefit Program only if (1) all claim procedures described in the applicable Benefit Program or, if applicable, this Plan have been exhausted, and (2) the action is commenced within six months days after a final decision on review is sent.

9.5 Compliance with Patient Protection and Affordable Care Act of 2010. Notwithstanding any provision in this Article IX to the contrary, the claims and appeals procedures relating to a group health plan will comply with the Patient Protection and Affordable Care Act of 2010 and the regulations and other guidance issued thereunder, as applicable, including any deadlines related to adverse benefit determinations and a claimant's right to request an external review of certain adverse benefit determinations.

ARTICLE X
AMENDMENT AND TERMINATION

10.1 Amendment. Notwithstanding any provision in this Plan or any Benefit Program to the contrary, the Plan Sponsor reserves the right, without the consent of any person (including any participant who has retired or otherwise terminated) to (i) prospectively, or retroactively, amend or modify this Plan and any Benefit Program from time to time in any manner it deems appropriate; (ii) add or delete Benefit Programs as a part of this Plan, such addition or deletion to be evidenced by appropriate endorsements or changes in Appendix A; and (iii) to apply any amendment to any or all participants (including any participant who has retired or otherwise terminated).

10.2 Termination. Notwithstanding any provision in this Plan or any Benefit Program to the contrary, the Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time, and may apply such termination to any or all participants (including any participant who has retired or otherwise terminated).

10.3 Plan Sponsor Action. The Plan Sponsor may act by action of its board of directors or any authorized officer or committee.

ARTICLE XI
MISCELLANEOUS

11.1 Non-Alienation of Benefits. No benefit, right or interest of any participant or beneficiary under the Plan will be subject to anticipation, alienation, sale, transfer, assignment pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law, such as a qualified medical child support order.

11.2 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification to the Plan, will operate or be construed to give any person any legal or equitable right against the Plan Sponsor or any other Employer, except as expressly provided in this Plan or required by law, or create a contract of employment with any employee, obligate the Employer to continue the service of any employee, or affect or modify the terms of an employee's employment in any way.

11.3 Governing Laws. The Plan will be construed and enforced according to the laws of the State of Missouri to the extent not preempted by ERISA or other applicable Federal law which will otherwise control.

11.4 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provision of the Plan, and the Plan will be construed and enforced as if the invalid or unenforceable provision had not been included in the Plan.

11.5 Construction. The captions contained in this Plan are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way will affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form will be construed as though they also include the plural, where applicable, and references to the masculine, feminine and the neuter are interchangeable.

ARTICLE XII
HIPAA PRIVACY AND SECURITY REQUIREMENTS

12.1 Use and Disclosure of Protected Health Information. Notwithstanding any provision in this Plan or a Benefit Program to the contrary, each Benefit Program which is a "health plan" within the meaning of 45 C.F.R. § 106.103 (referred to as a "Covered Entity") will use and disclose Protected Health Information (as hereinafter defined) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and implementing regulations issued thereunder (45 C.F.R. Parts 160-164). Specifically, the Covered Entity will use and disclose Protected Health Information for purposes related to health care treatment, payment for health care and health care operations. The insurance carriers for any insured health plans are responsible for keeping protected health information private and secure in accordance with HIPAA and the regulations issued pursuant to HIPAA. The Plan prohibits any intimidating or retaliatory act against any participant or Beneficiary for exercising his or her HIPAA rights, or any requirement that he waive his or her HIPAA rights.

12.2 Special Definitions.

"Individually Identifiable Health Information" means health information (including genetic information) that is created or received by the Covered Entity or the Plan Sponsor which relates to the past, present or future physical or mental health or condition of an individual or the

past, present or future provision of health care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

"Plan Administration Functions" means administrative functions performed by the Plan Sponsor on behalf of the Covered Entity and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

"Protected Health Information" means Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. 162.103 (i.e., which includes the Internet, Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disc, or compact disc media); or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (i) employment records held by the Plan Sponsor in its role as employer; (ii) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; and (iii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

"Treatment" means 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 a third party; 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.

12.3 Certification by the Plan Sponsor. Neither the Covered Entity nor any health insurance issuer or business employee servicing the Covered Entity will disclose a participant's Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Covered Entity has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.

12.4 Sponsor Covenants. The Plan Sponsor agrees to:

(a) not use or further disclose Protected Health Information other than as permitted or required by the plan document or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Covered Entity agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;

(c) not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by the individual with respect to whom the Protected Health Information relates;

(d) not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual with respect to whom the Protected Health Information relates;

(e) report to the Covered Entity any use or disclosure of Protected Health Information of which it becomes aware that is not permitted under the Covered Entity's privacy policies and procedures or the HIPAA privacy regulations;

(f) make Protected Health Information available to an individual in accordance with HIPAA's access requirements;

(g) make Protected Health Information available for amendment by an individual and incorporate any amendments to Protected Health Information in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures;

(i) make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Covered Entity available to the HHS Secretary for the purposes of determining the Covered Entity's compliance with HIPAA; and

(j) if feasible, return or destroy all Protected Health Information received from the Covered Entity that the Plan Sponsor still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

12.5 Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained. In accordance with HIPAA, only the following employees or classes of employees of the Plan Sponsor ("privacy officials") may be given access to Protected Health Information: the Privacy Officer; and other members of the HIPAA privacy team designated pursuant to the Covered Entity's HIPAA Privacy Policies and Procedures.

12.6 Limitations of Protected Health Information Access and Disclosure. The privacy officials may only have access to and use and disclose Protected Health Information for Plan Administration Functions that the Plan Sponsor performs on behalf of the Covered Entity.

12.7 Noncompliance Mechanism. The privacy officials will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Protected Health Information and breach or violation of or noncompliance with the provisions of this Article XII. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Covered Entity, and will cooperate with the Covered Entity to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each person causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any person, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

12.8 Electronic Protected Health Information. If the Plan discloses electronic Protected Health Information to the Plan Sponsor (other than summary health information or enrollment/disenrollment information disclosed pursuant to 45 C.F.R. §164.504(f)(1)(ii) or (iii) or information permitted to be disclosed pursuant to an individual authorization under 45 C.F.R. §164.508), the Plan Sponsor will:

(k) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;

(l) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(m) Ensure that any agent, including subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect such information; and

(n) Report to the Plan any security incident of which the Plan Sponsor becomes aware.

ARTICLE XIII
GROUP HEALTH PLANS

13.1 COBRA Rights. With respect to each Benefit Program which is a group health plan within the meaning of section 601 of ERISA, any COBRA provision in such Benefit Program will govern, in the event that a Benefit Program does not contain a COBRA provision, each participant and his or her family members may have the right to purchase continuation coverage for a temporary period of time set forth in COBRA, if coverage under the group health plan terminates due to certain COBRA qualifying events (such as termination of employment, reduction in work hours, divorce, death, or a child ceasing to meet the definition of dependent under the terms of the group health plan). In general, a participant or family member must elect COBRA continuation coverage within 60 days following the date of the qualifying event, or if later, the date notice of the qualifying event is provided to the individual. If continuation coverage is elected, the individual will be responsible for paying the full cost of continuation coverage plus an administrative fee.

13.2 Qualified Medical Child Support Orders. With respect to each Benefit Program that is a group health plan within the meaning of section 609(a) of ERISA, the Plan will comply with terms of a "qualified medical child support order" as defined in section 609(a) of ERISA, which recognizes the right of a child of a participant to receive benefits for which the participants and beneficiaries generally are eligible to receive under the group health plan. participants and beneficiaries may obtain a copy of the Plan's procedures relating to qualified medical child support orders from the Plan Administrator.

13.3 Newborns' and Mothers' Health Protection. With respect to each Benefit Program that is a group health plan providing maternity benefits, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal 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 the above periods. In any case, such group health plan will not require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. Such coverage will be subject to all other terms of the Benefit Program, such as deductibles, copays, and coinsurance.

13.4 Women's Health and Cancer Rights Act of 1998. To the extent any applicable Wellness Program, which is a group health plan, provides benefits for mastectomies, it will provide, for an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, and prosthesis and coverage for physical complications of all stages of the mastectomy, including lymphedemas. Such coverage will be subject to all other terms of the Benefit Program, such as deductibles, copays, and coinsurance.

13.5 Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan will be subject to the special enrollment, pre-existing condition limitations, certification, nondiscrimination in health status, privacy, security, and electronic interchange provisions of the Health Insurance Portability

and Accountability Act of 1996, as amended ("HIPAA"). This provision will be interpreted and applied to give a covered person only those rights as prescribed under HIPAA and the rulings and regulation issued thereunder. This provision will not apply to the extent HIPAA provisions are set forth differently in an applicable Benefit Program, except to the extent such HIPAA provisions in an applicable Benefit Program fail to comply with the requirements of HIPAA, in which case this provision will govern.

13.6 Family Medical Leave Act of 1993 (FMLA). The Employer will maintain benefits under each Benefit Program that is a group health plan for an employee on an Employer-approved FMLA leave on the same terms and conditions as if the employee had continued to work. Unless otherwise specified in a Benefit Program, an employee on an unpaid leave of absence will be responsible for any required contributions on an after-tax, month-to-month basis. Such contributions must be received by the Plan Administrator no later than 30 days after the beginning of the coverage month.

13.7 Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). A participant who is performing service in the uniformed services and is covered under the Plan is entitled to continue coverage for himself and dependents if applicable, provided the participant elects to continue coverage for the period beginning on the date of the participant's absence for purposes of performing uniformed service begins, and ending on the earlier of: (a) 24-months later; or (b) the date on which the participant fails to return from service or to apply for a position of employment as provided in USERRA or the regulations thereunder.

13.8 Mental Health Parity. Each Benefit Program that is a group health plan will comply with the requirements of the Mental Health Parity Act of 1996. This generally means that it will not place annual or lifetime maximums for mental health benefits that are lower than the annual and lifetime maximums for physical health benefits. Such coverage will be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits. Effective for Plan Years beginning after October 3, 2009, Each Benefit Program that is a group health plan and that provides both medical and surgical benefits and mental health benefits or substance use disorder benefits (a "Parity-Required Program") will comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008. This generally means that a Parity Required Program: (1) will not impose an annual or lifetime limit on mental health or substance use disorder benefits that is different from any annual or lifetime limit imposed on medical or surgical benefits; (2) will not impose treatment limitations, cost sharing, deductibles, copayments, coinsurance or out of pocket requirements on mental health or substance use disorder benefits that are more restrictive than the predominant requirements that apply to substantially all medical or surgical benefits, and no separate such requirements will apply only to mental health or substance use disorder benefits; (3) will not limit mental health or substance use disorder benefits for services from out-of-network providers in a manner different from such limits on medical or surgical benefits; and (4) the criteria for medical necessity determinations for mental health or substance use disorder benefits will be made available to participants, beneficiaries, or contracting providers upon request in accordance with applicable regulations, and the reasons for any denial of mental health or substance use disorder benefits will be made available to the participant or beneficiary on request or as otherwise required in accordance with regulations.

13.9 Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Effective April 1, 2009, with respect to any Benefit Program that is a group health plan, the Benefit Program will comply with the Children's Health Insurance Program Reauthorization Act of 2009. This generally means that the plan will allow a 60-day special enrollment right for employees and dependent children under the following two circumstances: (i) termination of coverage due to loss of eligibility under Medicaid or a state-sponsored children's health insurance program ("CHIP"); and (ii) becoming eligible for assistance under Medicaid or CHIP to help pay for coverage under the Benefit Program.

ARTICLE XIV
ERISA RIGHTS

As a participant ("you") in the 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. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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. 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.

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APPENDIX A – BENEFIT PROGRAMS

Benefit Programs	**Insurance Company or Third Party Administrator**
Medical Plan (self-insured beginning in 2019)	Excellus BlueCross BlueShield Hinge Health HSA Bank (Health Savings Accounts) Medical Alight (formerly Consumer Medical)
Dental Plan (self-insured)	Guardian
Vision Plan (self-insured)	Guardian
Critical Illness	Guardian
Accident Insurance	Guardian
Life/AD&D Insurance (basic and voluntary)	The Standard
Short-Term Disability	Guardian
Long-Term Disability	Guardian
Flexible Spending Account (salary reduction arrangement)	Lifetime Benefit Solutions
Employee Well-Being Benefits	LifeWorks (EAP Services) Headspace (Stress release and related services)
Non-ERISA Voluntary Benefits (discount programs, pet insurance, auto/home insurance)	BenefitHub

APPENDIX B - ELIGIBILITY

Full-time employees working 30 or more hours per week are eligible for coverage as of the first day of employment.

Part-time non-union employees working 20 to 29 hours per week are eligible for coverage (other than short and long-term disability) as of the first day of employment.

Employees covered by a collective bargaining agreement may be subject to different eligibility waiting periods and other requirements as set forth in their applicable bargaining agreement.