

Magna International of America, Inc.

Welfare Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective October 14, 2024

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INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, “Benefit Booklets”), is intended to serve as the Summary Plan Description (“SPD”), as required by the Employee Retirement Income Security Act of 1974 (“ERISA”). The SPD describes the benefits provided by the Magna International of America, Inc. Employee Welfare Benefit Plan (the “Welfare Benefit Plan”), the Magna International of America, Inc. Life Insurance Plan (the “Life Insurance Plan”) and the Magna International of America, Inc. Long Term Disability Plan (the “LTD Plan”) for eligible employees and eligible dependents of Magna International of America, Inc. and other affiliated entities of Magna International of America, Inc. that are participating employers in the Plan (an “Employer”). The Welfare Benefit Plan, the Life Insurance Plan and the LTD Plan may be referred to in this summary as the “Plan”.

Magna International of America, Inc. also offers its employees the Magna International of America, Inc. Cafeteria Plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide employees Health Care and Dependent Care Flexible Spending Accounts and the opportunity to make pre-tax contributions toward certain benefits.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns’ and Mothers’ Health Protection Act (NMHPA), the Women’s Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), Michelle’s Law, the Consolidated Appropriations Act of 2021 (including the No Surprises Act and the Transparency in Coverage provisions) and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act and subsequent legislation (collectively referred to as the Affordable Care Act).

The Medical coverage, Prescription Drug coverage, Dental coverage, Short Term Disability and spending accounts are self-insured and administered under contracts with service providers. All other benefits are provided under insurance contracts. All benefits are summarized in this document and in the Benefit Booklets (as defined below).

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will govern.

The applicable Benefit Booklets for certain plans describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. You may also access provider directories on the website of the applicable Claims Administrator or insurance company, or you can call the phone numbers indicated in the Benefit

Booklets. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on page 53.

Magna International of America, Inc. reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, the Employer has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by the Employer or to interfere with the Employer's right to discharge any employee at any time.

ELIGIBILITY

ELIGIBLE EMPLOYEES

Generally, you are considered an “eligible employee” and are eligible to participate in the Plan if you are:

- A regular full-time salaried or hourly employee of an Employer regularly scheduled to work at least 30 hours-per-week.

Continuous active service with one Employer will be counted as like service with a subsequent Employer, if the later service begins within 30 days after the earlier service ends.

Effective September 1, 2022, the period you must wait to participate in the Plan will be 30 days or less. Employees covered by a collective bargaining agreement may have a different waiting period. Please see your local Human Resources representative for this information.

INDIVIDUALS NOT ELIGIBLE

You are not eligible to participate in the Plan if you are:

- regularly scheduled to work less than 30 hours per week,
- a variable hour employee who the Company determines is not a full-time employee working 30 hours per week during the most recent standard measurement period or initial measurement period, as applicable, or
- a leased employee.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

ELIGIBILITY FOR MEDICAL AND PRESCRIPTION DRUG BENEFITS

Employees may be eligible for benefits under this Plan if they satisfy the criteria below.

- If you are regularly scheduled to work 30 or more hours per week, you are deemed to be a Full-Time Employee.
- If you are a Part-Time, Variable Hour or Seasonal Employee who works an average of 30 hours per week under the lookback method described below.

Refer to Appendix B for definitions of the capitalized terms in this section.

The lookback method works like this. To determine whether you are eligible to participate in the Plan, the Employer will measure your Hours of Service from October 13th of year 1 through October 12 of year 2. This October 13-October 12 timeframe is called the Standard Measurement Period. If you average at least 30 Hours of Service a week during the Standard Measurement Period, you will be eligible to participate in the Plan’s Medical benefits for the Standard Stability Period, which is the plan year beginning January 1st following the end of the Standard Measurement Period. You will be eligible for Medical benefits for the entire Standard Stability Period, even if your hours or wages decrease during

the Standard Stability Period, so long as you remain an employee and continue to make any required contributions toward your coverage.

Here is an example of how the lookback method will work:

Ann has 1642 hours of service from October 13, 2021 through October 12, 2022, which is more than 30 Hours of Service a week on average during the Standard Measurement Period. She is therefore considered full-time for the Plan's Standard Stability Period, and will be eligible for the Plan's Medical benefits from January 1, 2023 through December 31, 2023.

Each year, the Employer will calculate how many Hours of Service each Part-Time, Variable Hour or Seasonal Employee has worked during the Standard Measurement Period and will inform you if you are eligible for Medical benefits prior to the next Standard Stability Period.

If you experience a period of 13 consecutive weeks (or longer) without an Hour of Service—either because you terminate employment or are absent for some other reason—you will have a Break in Service and you will be treated as a New Employee to the extent permitted by law (see the rules that apply to New Employees below). The Plan Administrator may, in its discretion, determine that you have a Break in Service using an alternate “Rule of Parity.” Refer to the definition of Break in Service in Appendix B for a description of the Rule of Parity.

New Employees

You are considered a New Employee for purposes of eligibility for the Plan's Medical benefits if you did not work for the entire Standard Measurement Period before the plan year. When you are hired as a New Employee, the Employer will classify you as either New Full-Time, New Part-Time, Variable Hour, or Seasonal for purposes of eligibility for the Plan's Medical benefits.

New Full-Time Employee

If you are regularly scheduled to work at least 30 hours per week on your date of hire, the Employer will classify you as a New Full-Time Employee and you will be eligible for the Plan's Medical benefits following completion of the waiting period.

Variable Hour/New Part-Time/Seasonal Employee

If the Employer classifies you as a Variable Hour Employee, a New Part-Time Employee or a Seasonal Employee, the Employer will measure your Hours of Service over an Initial Measurement Period to determine whether you average over 30 Hours of Service a week. Interns and co-op students are classified as Variable Hour Employees. Your Initial Measurement Period will begin on the first of the month following your date of hire, and will end 12 months later.

If you average at least 30 Hours of Service during the Initial Measurement Period, you will be notified that you are eligible for coverage for a period of time following the Initial Measurement Period called the Initial Stability Period, and you will be given an opportunity to elect Medical coverage. If elected, your Medical coverage will begin no later than the first of the month following 13 full calendar months after your date of hire. If your Initial Stability Period spans two plan years, you will be given another opportunity to elect Medical coverage or change your Medical coverage election at annual enrollment along with all other eligible employees.

If you average less than 30 Hours of Service during the Initial Measurement Period, you will not be eligible for Medical coverage during the Initial Stability Period.

Once you have worked an entire Standard Measurement Period, your eligibility will be measured during the Standard Measurement Period as described in the previous section.

What if you change job classifications during the Initial Measurement Period? If you are hired as a new Variable Hour, Seasonal, or New Part-Time Employee, but during the Initial Measurement Period you are moved to a job classification that, had you been hired into that job classification originally, you would have been a New Full-Time Employee, you will be eligible for coverage on the first of the fourth month following the job classification change. If you would be eligible sooner during an Initial Stability Period, you will be eligible on the first day of the Initial Stability Period.

See Appendix B for Additional Information

The lookback method for determining eligibility is based on IRS regulations. See Appendix B for definitions related to the lookback method.

Individuals Not Eligible for Medical and Prescription Drug Benefits

You are not eligible to participate in the Plan's Medical and Prescription Drug benefits if you are:

- a leased employee,
- an independent contractor, or
- a member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

Eligibility Determinations are Made by the Plan Administrator

It is solely within the authority of the Plan Administrator to determine whether you are eligible for Medical and Prescription Drug benefits under this Plan. A person the Plan Administrator determines is not an employee and who is later required to be reclassified as an employee will only be eligible prospectively, provided all other eligibility requirements are met.

Special Eligibility Rules

If you are re-hired as a Full-Time Employee within six months after your date of termination, you are not required to satisfy a new waiting period.

If you are a Full-Time Employee who was hired by an affiliate of the Company outside of the United States and you are transferred to a United States location of an Employer, you are not required to satisfy a waiting period.

Eligible employees who reside in Canada, but work in the United States and are paid through U.S. payroll, have the option to enroll in the U.S. health care plan (medical, prescription drug, dental and vision) and enroll their spouse and dependents in the Canadian plan for extended health care and dental. This option is available to employees provided the group by whom they are employed has at least 3 employees enrolled in this program. Should employees be eligible for and elect this option, their pre-tax contributions will be determined by the level of coverage they select (employee only, two person or family.) All deductions will be made in U.S. dollars.

ELIGIBLE DEPENDENTS

Medical, Prescription Drug, Dental and Vision

The following dependents are eligible for Medical, Prescription Drug, Dental and Vision coverage offered under the Plan:

- Your legally married spouse (including a same-sex spouse and a common law spouse);
- Your children through the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26. You must notify your Human Resources representative in writing of the condition no later than 31 days after the child turns 26.

Your eligible dependents can be enrolled in the Medical, Prescription Drug, Dental and Vision coverage under the Plan only if you (the employee) are enrolled.

If you and your spouse work for the same division, you can enroll your spouse as a covered dependent under your coverage and your spouse would waive their coverage. If you are married to another employee of a different Magna division and you are both eligible for Medical coverage, both you and your spouse must be enrolled in your own division's coverage. In other words, you cannot enroll your spouse as a covered dependent under your coverage if you and your spouse work for different divisions. If you have children and enroll for family coverage, the following special rules apply:

- The children must be enrolled in the coverage of the division whose employee was born first in the year. For example, if you were born in May and your spouse was born in September, you must enroll the children in your coverage.
- If you are enrolled for single coverage and your spouse is covering more than one child under his/her division's coverage, your division will waive your contribution for coverage.
- If both you and your spouse have elected the same health plan (gold, silver or bronze) with the same deductibles, coinsurance and out-of-pocket maximum, the divisions will adjust the deductible and the out-of-pocket limit to allow for the family levels for the division that is maintaining the family coverage. It is your responsibility to notify your division when you have reached the family level for the deductible and/or out-of-pocket limit, so that the Company can contact the Claims Administrator to make the adjustment. If you and your spouse elect a different health plan (for example, you elect the gold plan and your spouse elects the silver plan), the deductible and out-of-pocket limit cannot be adjusted.
- The rule in the preceding two bullet points do not apply when you elect employee plus one coverage (for one child). It applies only when family coverage is elected.

If your spouse is eligible for medical coverage through his or her non-Magna employer, your spouse must enroll in his or her employer's medical plan in order to be eligible for Medical coverage under this Plan. This rule does not apply if your spouse's medical coverage is unaffordable. Affordability for this

purpose is based on the amount that your spouse is required to contribute toward the cost of coverage under his or her employer's lowest cost, single coverage plan. If your spouse's annual contribution is greater than 50% of the total cost of the lowest-cost Medical option under this Plan, your spouse may waive coverage under his or her employer's plan and enroll in the Medical coverage under this Plan. However, if your spouse's annual contribution is equal to or less than 50% of the total cost of the lowest-cost Medical option under this Plan, your spouse must enroll in his or her employer's plan in order to enroll in the Medical coverage under this Plan. This rule affects the spouse only – eligible children can be enrolled either in this Plan or in the spouse's employer's medical plan coverage.

This rule also does not apply if your spouse is only eligible for a limited health plan from his or her non-Magna employer. A limited health plan means:

- A short-term limited duration plan;
- A plan intended to supplement comprehensive major medical coverage, such as an accident insurance or hospital indemnity plan;
- A plan that provides a payment for a specified illness, such as cancer or a heart attack; or
- An excepted benefit plan, such as a standalone dental or vision plan or a health flexible spending account.

If your spouse is eligible and is enrolled in both the spouse's employer's medical plan and Medical coverage under this Plan, your spouse will not be allowed to make contributions to a health savings account (HSA). Therefore, if your spouse or your spouse's employer contributes to an HSA, you should not enroll your spouse in Medical coverage under this Plan.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

Your dependent children include:

- Your biological children,
- Stepchildren,
- Legally adopted children,
- Foster children,
- Children who are placed in your home for adoption, and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Dependents Not Eligible

The following individuals are not eligible for Medical, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A spouse who is an enrolled employee under the Plan;
- Your parent or spouse's parent.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Dependent Life

The following dependents are eligible for Basic and Supplemental Dependent Life offered under the Life Insurance Plan:

- Your legally married spouse, including a same-sex spouse who is under age 65, and
- Your or your spouse's natural child or stepchild, or legally adopted child under age 26.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Health Care Flexible Spending Account (FSA)

For purposes of the Health Care FSA your dependents include:

- Your legal spouse (including a same sex spouse),
- Your children until the end of the month in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes.)

Dependent Care Flexible Spending Account (FSA)

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code),
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets provided by the applicable insurance companies and/or service providers.

Qualified Medical Child Support Orders

The Welfare Benefit Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of the Welfare Benefit Plan's procedures governing QMCSO determinations, free of charge, by contacting your local Human Resources representative.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative

process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Welfare Benefit Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Welfare Benefit Plan, due to their age for example, cannot be added under a QMCSO.

Notification

If you experience a change in status (see pages 12-14), you must notify the Employer within 31 days in order to make a change in your election during the year. The notice must be in writing and contain the change in status event, the date of the event, and your requested change and must be sent to your local Human Resources representative.

In order to preserve your dependent's COBRA rights, you must notify your local Human Resources representative in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

ENROLLMENT

NEW EMPLOYEES

When you begin working at a participating Employer, you will receive the information necessary to enroll in the Plan. You are eligible for and will automatically be enrolled in the following:

- Basic Life/Basic Dependent Life
- Basic Accidental Death and Dismemberment (AD&D)
- Employee Family Assistance Plan
- Short-Term Disability
- Core Long-Term Disability
- Business Travel Accident Insurance

You must affirmatively enroll yourself and your eligible dependents within the waiting period specified by your location for:

- Medical (including Prescription Drug coverage)
- Dental
- Vision
- Supplemental Life
- Supplemental Dependent Life
- Voluntary AD&D
- Buy-Up Long-Term Disability
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

If you do not enroll yourself and your eligible dependents in Medical coverage within your waiting period, or within a period of time of up to 31 days following the end of your waiting period (if allowed by your division), you will be automatically enrolled in employee-only coverage in the lowest-cost option. You will have to wait until the next Open Enrollment period to add dependents or enroll in Dental, Vision, Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverages, unless you experience a change in status.

If you enroll in Medical coverage, you will automatically be enrolled in the appropriate level of Prescription Drug coverage. You may not separately enroll for the Prescription Drug coverage.

Please refer to the applicable Benefit Booklets for additional details on eligibility. Although enrollment may be automatic, coverage may not be automatic.

If you do not enroll for Supplemental Life, Supplemental Dependent Life, Supplemental AD&D coverage or Buy-up LTD when you are first eligible, you will have to wait until the next Open Enrollment period.

In general, your coverage under the Plan will begin on the day after you have satisfied your waiting period. If you become eligible for coverage later than your initial hire, your coverage will begin on the date you become eligible for coverage, if you have satisfied your waiting period. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

If you were a Part-Time Employee and become a Full-Time Employee (regularly scheduled to work at least 30 hours per week), you are immediately eligible to enroll in coverage if you have satisfied your waiting period. If you were a Full-Time Employee and become a Part-Time Employee (regularly scheduled to work less than 30 hours per week), you will lose eligibility for coverage and will be offered COBRA continuation coverage under the Medical, Dental, Vision, EFAP, and Health Flexible Spending Account coverages.

If you enroll yourself or a dependent in the Medical, Dental, Vision, Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account benefits mid-year due to a change in status, coverage will be effective as soon as administratively feasible following the date your local Human Resources representative receives your timely request for enrollment due to a change in status. If you have made a change to your Medical coverage due to marriage or the birth or adoption of a child, your election change will be effective as of the date of the marriage or the birth or adoption (or placement for adoption).

If you enroll on time, your coverage will begin on the later of the following: the date you enroll or the date you satisfy the eligibility requirements. Your local Human Resources representative will advise you of the waiting period that applies at your location.

Current Employees

Open Enrollment is held every fall. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You'll receive information, including instructions on how to enroll, before Open Enrollment each year.

HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical benefits provided under the Welfare Benefit Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of marriage, birth, adoption or placement for adoption. For all other events, coverage will be effective as soon as administratively feasible following your request for enrollment.

The Welfare Benefit Plan must allow a HIPAA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Welfare Benefit Plan. If you request this change, coverage will be effective as soon as administratively feasible following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact your local Human Resources representative.

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

You pay your share of the cost of Medical, Dental and Vision coverage on a pre-tax basis (see below for more information). The level of contribution is determined by the Employer.

Contributions to the Health Care and Dependent Care Flexible Spending Account are also on a pre-tax basis. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount.

If you are enrolled in Supplemental Life, Supplemental Dependent Life, Supplemental AD&D and Buy-Up Long-Term Disability coverage, you pay the cost for coverage on an after-tax basis. Contributions are deducted from your paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to your local Human Resources representative.

CAFETERIA PLAN – PREMIUM CONVERSION

Magna International of America, Inc. has established a premium conversion plan under the Cafeteria Plan in order for you to be able to pay your contributions for the Medical, Dental and Vision coverages and the Health Care and Dependent Care Flexible Spending Accounts provided under the Plan on a pre-tax basis.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following plan year (January 1 through December 31).

CHANGES IN STATUS

Supplemental Life, Dependent Life, Supplemental AD&D and Buy-Up Long-Term Disability Mid-Year Changes

You cannot make changes to your supplemental life, dependent life, supplemental AD&D and Buy-Up Long-Term Disability elections during the Plan Year, except that:

- you can drop coverage if you terminate employment or you or your dependents become ineligible for benefits under the Plan; or
- you can make changes to your dependent life coverage for children following birth or adoption of a child or for a spouse following marriage or divorce.

Medical, Dental, Vision and Flexible Spending Account Mid-Year Changes

You may be able to change your Medical, Dental, Vision and Health Care Flexible Spending Account or Dependent Care Flexible Spending Account elections during the Plan Year if you experience a change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify your local Human Resources representative within 31 days of the event, or 60 days for certain events as described under HIPAA Special Enrollments in this booklet. If you do not notify your local Human Resources representative within the 31-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree, etc.) These rules apply to elections you make for your Medical, Dental, Vision, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account. The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or ending employment;
 - A strike or lockout;
 - Starting or returning from an unpaid leave of absence;
 - Changing from part-time to full-time employment or vice versa; and
 - A change in work location;

- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area;
- **HIPAA Special Enrollment Events:** Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA);
- **Unpaid leave:** Beginning or returning from an unpaid leave.

Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, you may make a corresponding change to your Medical, Dental, Vision and Health Care Flexible Spending Account elections. If you or your eligible dependents lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental and Vision elections.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Welfare Benefit Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Welfare Benefit Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Welfare Benefit Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

COST OR COVERAGE CHANGE EVENTS

In some instances, you can make elections if the type of coverage or cost of coverage changes. These rules do not apply to the Health Care Flexible Spending Account. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Cost Changes

If the Plan Administrator determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverages, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election.

Any change in the cost of your plan option that the Plan Administrator determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Coverage Changes

The following are additional situations in which you may change your current coverage.

Restriction or Loss of Coverage — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered “significantly restricted” if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.

Addition to or Improvement in Coverage — If the Welfare Benefit Plan adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

Changes in Coverage under Another Employer Plan — If your spouse or dependent child(ren) is employed and his or her employer’s plan allows for a change in your family member’s coverage (either during that employer’s Open Enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Welfare Benefit Plan. For example, if your spouse elects family coverage during his or her employer’s open enrollment period, you may request to end your coverage under the Welfare Benefit Plan.

Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children’s health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under the Welfare Benefit Plan.

Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or
- You make a change to your or your spouse’s regular work schedule that increases or decreases your need for dependent care.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for three specific types of leave: Family and Medical Leave of Absence, Active Military Leave of Absence and Disability Leave of Absence. For more information about other types of leave of absence, contact your local Human Resources Department.

FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact your local Human Resources Department.

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, Employee Family Assistance Plan and Health Care Flexible Spending Account coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by paying for coverage during your leave on an after-tax basis or by making up the contributions that were missed upon return from FMLA leave. You also have the option to suspend your health coverage during the leave.

If your Health Care Flexible Spending Account coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care Flexible Spending Account coverage amount.)

Your Basic Life, AD&D, Basic Spouse and Dependent Life, Short-Term Disability and Core Long-Term Disability coverages will continue during an FMLA leave. Your Supplemental Life, Supplemental Dependent Life, Supplemental AD&D, Buy-Up Long-Term Disability coverage will **continue** during FMLA leave if you continue to pay the required after-tax contributions during your leave. Alternatively, you may make arrangements to make up your missed contributions upon return from leave. Your contributions to the Dependent Care Flexible Spending Account will continue during a paid leave, but will be suspended if the leave is unpaid.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see page 18).

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Employee Family Assistance Plan and Health Care Flexible Spending Account coverage for up to 24 months as long as you give the Employer advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from the Employer, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

The Life, AD&D and disability coverages will continue during your military leave. You will be required to make up any missed contributions upon your return to work after the military leave. However, participation in the Dependent Care Flexible Spending Account will terminate.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at an Employer, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

DISABILITY LEAVE

If Your Disability Leave Begins on or after January 1, 2025

If you begin an approved disability leave on or after January 1, 2025 due to disease, injury or pregnancy, you must continue to make your contributions for Medical, Dental and Vision coverage for the first twelve months of the disability leave (six months of Short-Term Disability and the first six months of Long-Term Disability). Your Company-subsidized Medical, Dental and Vision coverage will continue until the first to occur of (a) 12 months from the date your disability leave commenced; (b) the

date you are no longer disabled under the terms of the Short-Term Disability or Core Long-Term Disability Plan; or (c) the date you qualify for Medicare due to age, disability or on any other basis. The first six months of Company-subsidized coverage will run concurrent with Short-Term Disability leave. At the beginning of the leave, Human Resources will notify you whether your contributions will be made via payroll or through a separate payment arrangement. At the end of the 6-month period of Company-subsidized coverage that runs concurrent with Short-Term Disability, you will be offered the opportunity to enroll in COBRA continuation coverage. The last six months of Company-subsidized coverage would continue after you qualify for Long-Term Disability benefits and elect COBRA, and this period will run concurrently with COBRA continuation coverage. At the end of the 12-month period of Company-subsidized coverage, you will still be eligible to continue your COBRA continuation coverage for the remaining months in your maximum coverage period at 102% of the cost of coverage.

If at any point during the 12-month period of the subsidized coverage, you are no longer disabled i.e. no longer approved for short or long-term disability and do not return to work at the end of your leave, you will be offered the opportunity to elect or continue COBRA continuation coverage at your cost for any months remaining in your maximum coverage period.

Your maximum coverage period for purposes of COBRA continuation coverage begins on the date you qualify for Long-Term Disability benefits, or the end of your Short-Term Disability leave if you do not qualify for Long-Term Disability benefits. If you were to die or become eligible for Medicare before the end of the 12-month period of Company-subsidized coverage, coverage for your dependents will end and they may be offered COBRA continuation coverage. See the COBRA section below.

You may enroll in a different Medical coverage option during the open enrollment period; however, if you enroll for coverage that provides richer benefits, you will be required to pay any related increase in cost during the 12-month period of Company-subsidized coverage. For example, if you are enrolled in the silver option at the time of disability and you enroll in the gold option at a subsequent open enrollment period, you will be required to pay the difference in cost between the gold option and the silver option.

You must also continue to make your contributions for any voluntary benefits you wish to maintain during your leave, such as voluntary life insurance or buy-up disability. These benefits will remain in effect until your termination of employment, as long as you timely make your contributions. During the first six months of your leave, Human Resources will notify you whether your contributions will be made via payroll or through a separate payment arrangement. After the initial six-month period, you should contact Human Resources to make payment arrangements.

Employees covered by a collective bargaining agreement may be subject to different rules regarding continuation of coverage during a disability leave; please refer to your collective bargaining agreement.

If Your Long-Term Disability Leave Began Before January 1, 2025

If you began an approved long-term disability leave before January 1, 2025 due to disease, injury or pregnancy, your contributions for Medical, Dental and Vision coverage for you and your eligible dependents are waived for the coverage options in which you are enrolled as of your date of disability until the earlier of (a) December 31, 2025, (b) the date you are no longer disabled under the terms of the Core Long-Term Disability Plan, (c) the date you qualify for Medicare due to age, disability or on any other basis, or (d) the end of a 29-month maximum coverage period available to you under COBRA continuation coverage. If you are still disabled at December 31, 2025 and have months remaining in the 29-month maximum coverage period, you may continue your COBRA coverage for the remaining months and you must pay 102% of the cost of coverage. The period of extended coverage beginning

on the date you qualify for Long-Term Disability benefits runs concurrently with COBRA continuation coverage.

If at any point during the period of the subsidized coverage you are no longer disabled and do not return to work at the end of your leave, you will be offered the opportunity to elect or continue COBRA continuation coverage at your cost for any months remaining in your maximum coverage period.

Your maximum coverage period for purposes of COBRA continuation coverage begins on the date you qualify for Long-Term Disability benefits, or the end of your Short-Term Disability leave if you do not qualify for Long-Term Disability benefits. If you were to die or become eligible for Medicare during the period of time in which your contributions are waived, coverage for your dependents will end and they may be offered COBRA continuation coverage for any remaining months in the maximum coverage period. See the COBRA section below.

You may enroll in a different Medical coverage option during the open enrollment period; however, if you enroll for coverage that provides richer benefits, you will be required to pay any related increase in cost during the period of time during which your contributions are waived. For example, if you are enrolled in the silver option at the time of disability and you enroll in the gold option at a subsequent open enrollment period, you will be required to pay the difference in cost between the gold option and the silver option.

Employees covered by a collective bargaining agreement may be subject to different rules regarding continuation of coverage during a disability leave; please refer to your collective bargaining agreement.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of any insurance contract or agreement, or by discontinuance of contributions by the Employer;
- The day on which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment or it may result because you average less than 30 Hours of Service during a Standard Measurement Period, and are not eligible for Medical benefits during the related Standard Stability Period;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain medical procedures) are described in the Benefit Booklets.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- For your dependent child, for Medical, Dental and Vision coverage, the end of the month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);

- The day on which your legally married spouse or child is no longer considered an eligible dependent (for example, date of divorce);
- The end of the pay period in which you stop making contributions required for dependent coverage; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Welfare Benefit Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Welfare Benefit Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical (including Prescription Drug coverage), Dental, Vision, Employee Family Assistance Plan and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by the Employer (such as Life, LTD, or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Welfare Benefit Plan when coverage would otherwise end because of a “qualifying event”. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage will be offered to each person losing group health coverage under the Welfare Benefit Plan who is a “qualified beneficiary”. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Welfare Benefit Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Welfare Benefit Plan provides to other participants or beneficiaries under the Welfare Benefit Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Welfare Benefit Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified

beneficiaries, including Open Enrollment and special enrollment rights. Under the Welfare Benefit Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Welfare Benefit Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of an Employer, you will have the right to elect COBRA if you lose your group health coverage under the Welfare Benefit Plan because either one of the following qualified events:

- A reduction in your hours of employment with the Employer; or
- The termination of your employment with the Employer (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of an Employer, you will have the right to elect COBRA if you lose your group health coverage under the Welfare Benefit Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse’s employment with the Employer (for reasons other than your spouse’s gross misconduct) or reduction in your spouse’s hours of employment the Employer; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Welfare Benefit Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee’s employment with the Employer (for reasons other than the employee’s gross misconduct) or reduction in the employee’s hours of employment;
- The parent-employee’s divorce; or
- You, the dependent child, cease to meet the definition of a “dependent child” under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Welfare Benefit Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Welfare Benefit Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform the Employer that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the former employee of an Employer, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Welfare Benefit Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the COBRA Administrator (see Contact Information) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the COBRA Administrator within the 31 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Welfare Benefit Plan's rules for adding a new dependent.

QMCSO

A child of the covered employee who is receiving benefits under the Welfare Benefit Plan pursuant to a qualified medical child support order (QMCSO) received by the Welfare Benefit Plan during the covered employee's period of employment with an Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Welfare Benefit Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the Employer of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify your local Human Resources representative in writing within 60 days of the date of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Welfare Benefit Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Welfare Benefit Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Employer requests it. Acceptable documentation includes a copy of the divorce decree or dependent

child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to your local Human Resources Department. If the above procedures are not followed or if the notice is not provided to the local Human Resources Department within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Welfare Benefit Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Welfare Benefit Plan's COBRA election notice and mail it to the COBRA Administrator at BASIC, P.O. Box 631084, Cincinnati, Ohio 45263-1084.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Welfare Benefit Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Choosing Between Medicare and COBRA Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period¹ to sign up, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Health Care FSA COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care Flexible Spending Account by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care Flexible Spending COBRA

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>. These rules are different for people with End Stage Renal Disease (ESRD).

coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule and the \$500 rollover will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Welfare Benefit Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Welfare Benefit Plan.

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Welfare Benefit Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred, subject to any amount that is rolled over. COBRA coverage for the Health Care Flexible Spending Account cannot be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Welfare Benefit Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Employer no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Welfare Benefit Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the Plan Administrator reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Plan Administrator and/or the insurance carriers may require repayment to the Welfare Benefit Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Trade Act

If you are receiving trade adjustment assistance ("TAA") benefits under the Trade Act of 2002 as amended (generally for workers whose employment is adversely affected by international trade such as increased imports or a shift in production to another country), you are eligible for TAA benefits due to a job elimination giving you COBRA rights, and you failed to elect COBRA continuation coverage during your initial 60-day COBRA continuation coverage election period, you may elect continuation coverage during a second 60-day period. This second 60-day period begins on the first day of the month in which you are determined to be TAA-eligible, provided you elect COBRA continuation coverage within six months after the date of the TAA-related loss of coverage. Any COBRA continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage initially lapsed.

The Trade Act of 2002 as amended also provided for a new tax credit of up to 72.5% of the cost of certain premiums paid for medical coverage, including COBRA continuation coverage for individuals

receiving TAA benefits. If you are receiving TAA benefits, you should check whether you are eligible to claim this tax credit.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA Administrator:

BASIC
P.O. Box 631084
Cincinnati, OH 45263-1084
1-800-444-1922

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep The Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Employer informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

COVERED AND NON-COVERED SERVICES

Refer to the Benefit Booklets provided by your applicable insurance company and/or Claims Administrator for a specific listing of covered and non-covered services under your benefits.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Welfare Benefit Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Welfare Benefit Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Welfare Benefit Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Welfare Benefit Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- 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 at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Welfare Benefit Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Welfare Benefit Plan.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Health Care Flexible Spending Account may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage.

This section explains how the Health Care Flexible Spending Account allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive in health care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed on page 8.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than \$2,500 per Plan Year of your own money to your Health Care Flexible Spending Account. This amount may be adjusted in future years and you will be notified of the adjusted maximum contribution amount during the open enrollment period. For 2023, the maximum contribution is \$2,850.

ELIGIBLE EXPENSES

The Health Care Flexible Spending Account is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Health Care Flexible Spending Account. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

You may submit claims for over-the-counter medications (including insulin) and equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

Below is a partial list of expenses eligible for reimbursement under the Health Care Flexible Spending Account:

- Medical Expenses
 - Deductibles
 - Copayments
 - Charges for routine check-ups, physical examinations, and tests connected with routine exams
 - Charges over the “reasonable and customary” limits
 - Expenses not covered by the medical plan due to exclusions or limitations
 - Drugs requiring a doctor’s written prescription that are not covered by the Plan
 - Over-the-counter drugs and certain other over-the-counter items such as bandages, crutches, menstrual care products and other supplies, but only to the extent applicable regulations permit
 - Insulin
 - Smoking cessation programs and related medicines
 - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
 - Other selected expenses not covered by the medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).
- Dental Expenses
 - Deductibles
 - Copayments
 - Expenses that exceed the maximum annual amount allowed by your dental plan
 - Charges over the “reasonable and customary” limits
 - Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
 - Vision examinations and treatment not covered by the Plan
 - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
 - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

INELIGIBLE EXPENSES

Below is a partial list of expenses **not** eligible for reimbursement under the Health Care Flexible Spending Account:

- Premiums
 - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
 - Premiums paid for Medicare
 - Premiums paid for long term-care Insurance
 - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Cosmetic procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.

- Expenses related to general health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.
- Long-term care expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care Flexible Spending Account.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

USE OR LOSE; \$500 ROLLOVER

IRS regulations stipulate that you must use all the money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year, or forfeit what remains, except that, up to \$500 of your account will be rolled over the next plan year. Your request for reimbursement must be filed by March 31st after the Plan Year in which funds are allocated to your Health Care Flexible Spending Account for expenses incurred during that Plan Year. **Any funds remaining in your Account greater than \$500 after that date will be forfeited.** Up to \$500 will be "rolled over" to the next plan year and can be used for expenses incurred at any time during the following plan year. The \$500 rollover may be adjusted in future years and you will be notified of the adjusted rollover amount during the open enrollment period. For 2023, the rollover amount is \$570.

Example: Fred elects to contribute \$1,200 to his Health Flexible Spending Account in 2022. At the end of the year, he has incurred only \$700 in eligible expenses. \$500 will "rollover" to 2023. For 2023, Fred elects to contribute \$600 to his Health Care Spending Account. He can be reimbursed for up to \$1,100 in 2023, consisting of the \$600 he elects to contribute in 2023 plus the \$500 rolled over from 2022.

With this "**use or lose**" rule, it is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. You will lose any unused amounts greater than \$500.

You may not use money in your Health Care Flexible Spending Account to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and must be more before reimbursement will be made. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account plus any amount rolled over from a prior plan year. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care Flexible Spending Account is BASIC.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Dependent Care Flexible Spending Account allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed on page 8.

CONTRIBUTION LIMITS

The IRS limits the amount you may contribute to your Dependent Care Flexible Spending Account. There is an overall annual maximum of \$5,000 (or \$2,500 each if you and your spouse file separate income tax returns). But another limitation also applies. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During 2022, Mary will earn \$41,500 from her job. Her husband will earn \$3,600 from his job. Mary's reimbursement from her Dependent Care Flexible Spending Account will be limited to \$3,600. She can choose to contribute no more than \$300 a month ($\$300 \times 12 = \$3,600$) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or \$250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or \$500 a month.

ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Dependent Care Flexible Spending Account include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you're married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Dependent Care Flexible Spending Account. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. If your coverage terminates mid-year, you may be reimbursed for claims incurred after the termination date and before the last day of the Plan Year (December 31), up to the remaining balance in your account. Claims must be filed by March 31st after the end of the Plan Year, as described in "Filing a Claim," below.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

INELIGIBLE EXPENSES

You cannot use the money in your Dependent Care Flexible Spending Account to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
 - Your children under age 19 (whether or not they are your tax dependents)
 - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Dependent Care Flexible Spending Account.

USE OR LOSE

It is important that you not contribute more than the dependent care expenses that you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year, or forfeit what remains. You must incur eligible expenses by December 31 in order for them to be eligible for reimbursement. Your request for reimbursement must be filed prior to March 31st after the Plan Year in which funds are allocated to your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

You may not use money in your Dependent Care Flexible Spending Account to pay health care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Dependent Care Flexible Spending Account is BASIC.

SPECIAL RULES AFFECTING DEPENDENT CARE ACCOUNTS

Several special rules apply to Dependent Care Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care Flexible Spending Account. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care Flexible Spending Account. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

CLAIMS AND APPEAL PROCESS

FILING A CLAIM

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claims Administrators – Fully Insured

The Plan provides the following benefits through contracts with the insurance companies listed below. The Vision, Life, Supplemental Life, Dependent Life, AD&D, Supplemental AD&D, Core LTD, Buy-Up LTD and Employee Family Assistance Plan benefits of the Plan are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Vision	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
Basic, Supplemental & Dependent Life, Accidental Death and Dismemberment (AD&D), Supplemental AD&D	The Hartford Group Life/AD&D Claims Unit P.O. Box 14299 Lexington, KY 40512-4299 Telephone: 1-8-563-1124 Fax: 1-866-954-2621
Core Long-Term Disability (LTD) and Buy-Up LTD	Insura The Hartford Attn: Group LTD Claims P.O. Box 14302 Lexington, KY 40512-4302 Telephone: 1-800-549-6514 Fax: 1-866-411-5613
Employee Family Assistance Plan (EFAP)	Workplace Options (WPO) 1-888-851-7032
Business Travel Accident	Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999

Claims Administrators – Self-Insured

Medical, Prescription Drug and Dental coverage, Short-Term Disability and the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account are self-insured. The Plan Administrator has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment under the Medical, Prescription Drug and Dental coverages, Short-Term Disability and the Health Care Flexible Spending Account. The Claims Administrator merely processes claims and does not insure that any expense will be paid. Benefits are paid out of the general assets of the Employer and are not guaranteed under a contract or policy of insurance. If the Plan does not pay eligible expenses, you may be liable for those expenses. If there are delays in processing claims, you will have no greater rights to interest or other remedies against the Claims Administrator than as otherwise afforded by law.

Medical	Blue Cross Blue Shield of Michigan (PPO) Key, Large and Auto Service Center P.O. Box 230555 Grand Rapids, MI 49523-0555 888-890-4943
Prescription Drugs	Express Scripts ATTN: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711
Dental	Delta Dental Attn: Customer Service P.O. Box 9085 Farmington Hills, MI 48333-9085
Short Term Disability	Hartford 1-866-407-8666
Spending Accounts	BASIC P.O. Box 6278 Manona, WI 53716 1-800-444-1922

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information.

For Medical and Prescription Drug benefits, the Plan will comply with additional claim and appeal rules required under the Affordable Care Act. These rules will not apply to standalone dental or vision claims, EFAP claims or Health Care Flexible Spending Account claims.

CLAIM-RELATED DEFINITIONS

Claim

Any request for Plan benefits made in accordance with the Plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Welfare Benefit Plan recognizes four categories of health benefit claims:

Urgent Care Claims

“Urgent care claims” are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Welfare Benefit Plan will defer to an attending provider to determine if a claim for group health plan benefits is urgent.

Pre-service Claims

“Pre-service claims” are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

“Post-service claims” are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

“Concurrent care claims” are claims for which the Welfare Benefit Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Welfare Benefit Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an “urgent care claim,” “pre-service claim,” or “post-service claim,” depending on when during the course of your care you file the claim. However, the Welfare Benefit Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate;
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for group health plan or long-term disability claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

INITIAL CLAIM DETERMINATION

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the

claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

If you do not follow the Plan's procedures for filing a pre-services claim with a group health plan, you will be notified of the failure and of the proper procedures to be followed in filing your claim. This notice will be provided to you as soon as possible within 5 days (24 hours in the case of a claim involving urgent care) following the failure. Notice can be oral, unless you request written notification. This notice procedure only applies to a claim received by the Claims Administrator, and your claim identifies a specific claimant; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the case of an adverse benefit determination by a group health plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the group health plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the group health plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For group health plan claims, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

In the case of an adverse benefit determination by a disability plan, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by the claimant to the disability plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the disability plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination made by the Social Security Administration and presented by the claimant to the disability plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the disability plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the disability plan relied upon in making the adverse benefit determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the disability plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health Care Flexible Spending Account (FSA) claims are considered non-urgent “post-service” claims.

Medical, Prescription Drug, Dental, Vision, EFAP & Health Care FSA Plans					Long-Term Disability and Short-Term Disability	Life & AD&D, Business Travel Accident, and Dependent Care FSA Plans
	Urgent Care Claims	Non-Urgent “Pre-Service” Claims	Non-Urgent “Post-Service” Claims	“Concurrent Care” Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

Medical, Prescription Drug, Dental, Vision, EFAP & Health Care FSA Plans					Long-Term Disability and Short-Term Disability	Life & AD&D, Business Travel Accident, and Dependent Care FSA Plans
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.

Medical, Prescription Drug, Dental, Vision, EFAP & Health Care FSA Plans					Long-Term Disability and Short-Term Disability	Life & AD&D, Business Travel Accident, and Dependent Care FSA Plans
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The appeals processes of any fully insured plans may vary somewhat. Please see your Benefit Booklets for more information on fully insured benefits.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed on pages 34-35. If you don't appeal on time, you lose your right to later object to the decision.

Group health plan coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Welfare Benefit Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan.

For group health plan or disability claims, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. The health care professional will not be the individual who was consulted in connection with the adverse benefit determination, or the individual's subordinate. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. For group health plan or disability claims, you also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For group health plan claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review for group health plan or disability plan claims, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your group health plan or disability plan claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 45. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- A description of your right to bring a civil action under ERISA following an adverse determination on review. The statement for a disability plan claim will describe any applicable contractual limitations period that applies to the claimant's right to bring an action, including the calendar date on which the contractual limitations period expires for the claim.

For a group health plan claim, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health and disability claims);
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims);
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures;
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For group health plan claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The health care provider;
- The claim amount (if applicable); and
- The denial code.

For a disability claim, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by the claimant to the disability plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the disability plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination made by the Social Security Administration and presented by the claimant to the disability plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the disability plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the disability plan relied upon in making the adverse benefit determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the disability plan do not exist.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and internal and external appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Internal Appeals Process

The internal claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the Plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to “days” mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical, Prescription Drug, Dental, Vision, EFAP & Health Care FSA Plans			Long-Term Disability and Short-Term Disability	Life & AD&D, Business Travel Accident, and Dependent Care FSA Plans
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period “tolled” until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

EXTERNAL REVIEW PROCEDURES FOR SELF-INSURED MEDICAL AND PRESCRIPTION DRUG BENEFITS

The external review process described in this subsection applies to any adverse benefit determination under the Medical and Prescription Drug coverage. A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the Welfare Plan is not eligible for the external review process.

STANDARD EXTERNAL REVIEW PROCEDURES

- Request for External Review. The claimant may file a request for an external review with the Plan, provided the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the 5th month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal Holiday.
- Preliminary Review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - (b) The adverse benefit determination or the final benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
 - (c) The claimant has exhausted the Plan's internal appeal process, unless the claimant is deemed to have exhausted the internal appeals process; and
 - (d) The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, the notification will describe the information or materials needed to make the request complete. The claimant will have until the end of the four-month filing period for requesting an external review, or 48 hours following the receipt of the notification, whichever is later, to perfect the request for external review.
- Referral to Independent Review Organization. The Plan will assign an "independent review organization" ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan will take action against bias to ensure independence by contracting with at least three IROs for assignments under the Plan and rotate claims assignments among them, or will incorporate other independent, unbiased methods for selection of IROs (such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(c) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. The failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination. Within one business day after making the decision, the IRO will notify the claimant and the Plan.

(d) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo (which means anew, from the beginning) and in accordance with established guidelines and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process described in the previous subsection.

(f) The assigned IRO must provide written notice to the claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review.

(g) The assigned IRO's decision notice will contain information required by the PPACA, including information sufficient to identify claims and treatment codes, a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant, a statement that judicial review may be available to the claimant, and current contact information for any applicable office of health insurance consumer assistance or ombudsman.

- Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW PROCEDURES

- Request for Expedited External Review. The claimant may make a request for an expedited review with the Plan at the time the claimant receives:
 - (a) An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, the availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
- Preliminary Review. Immediately following receipt of the expedited external review request, the Plan will complete a preliminary review of the validity of the claimant's request, utilizing the same standard for preliminary review described above in the "Standard External Review Procedures" subsection.

Immediately after completion of the preliminary review, the Plan will issue to the claimant the written notification described above in the "Standard External Review Procedures" subsection.

- Referral to Independent Review Organization. The Plan will assign an IRO to conduct the expedited external review under the same procedure described above for referring to an IRO in the "Standard External Review Procedures" subsection.

The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and in accordance with established guidelines, and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

- Notice of Final External Review Decision. The IRO will provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

The assigned IRO's written decision will contain information required by PPACA, including information sufficient to identify claims and treatment codes, a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the

claimant, a statement that judicial review may be available to the claimant, and current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

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

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

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Medical plan will pay out-of-network providers and facilities directly.
- The Medical plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059.

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

ACTS OF THIRD PARTIES

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Welfare Benefit Plan may cover your eligible health care (medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Welfare Benefit Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Welfare Benefit Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Welfare Benefit Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Welfare Benefit Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Welfare Benefit Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Welfare Benefit Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Welfare Benefit Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Welfare Benefit Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Welfare Benefit Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Welfare Benefit Plan back first, in full, out of such funds for any health care expenses the Welfare Benefit Plan has paid related to such illness or injury. You must pay the Welfare Benefit Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Welfare Benefit Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Welfare Benefit Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Welfare Benefit Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Welfare Benefit Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Welfare Benefit Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Welfare Benefit Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Welfare Benefit Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Welfare Benefit Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Welfare Benefit Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Welfare Benefit Plan considers necessary to exercise its rights or privileges under the Welfare Benefit Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, the Plan Administrator and the Employer to the extent of such payment.

MISSTATEMENT OF FACT

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans: Plan Name/Plan Number	Magna International of America, Inc. Employee Welfare Benefit Plan/Plan Number 502
	Magna International of America, Inc. Life Insurance Plan/Plan Number 510
	Magna International of America, Inc. Long Term Disability Plan/Plan Number 511
Plan Sponsor	Magna International of America, Inc. 750 Tower Drive Troy, MI 48098
Employer Identification Number	98-0095901
Plan Administrator	Magna International of America, Inc. 750 Tower Drive Troy, MI 48098 1-248-631-1100
Participating Employers	You may request a list of the participating Employers from the Plan Administrator.
Agent for Service of Legal Process	Magna International of America, Inc. 337 Magna Drive Aurora, Ontario L4G-7K1 Attn: Corporate Secretary
Plan Year	January 1 through December 31
Plan Type	Each Plan is a welfare benefit plan providing the following types of benefits: <u>Welfare Benefit Plan</u> ▪ Medical ▪ Prescription Drug ▪ Dental ▪ Vision ▪ Employee Family Assistance Plan ▪ Health Care Flexible Spending Account ▪ Short-Term Disability <u>Life Insurance Plan</u> ▪ Basic Life Insurance ▪ Supplemental Life Insurance ▪ Basic Dependent Life Insurance ▪ Supplemental Dependent Life Insurance ▪ Accidental Death and Dismemberment (AD&D) ▪ Supplemental AD&D ▪ Business Travel Accident Insurance

	<u>Long Term Disability Plan</u> ▪ Core Long-Term Disability (LTD) ▪ Buy-Up LTD Although the Dependent Care Flexible Spending Account is described in this SPD, it is not an ERISA plan.
Collective Bargaining Agreements	Some of the benefits under this Plan are maintained pursuant to the terms of collective bargaining agreements. A copy of the relevant collective bargaining agreement will be provided to you on request to the Plan Administrator.
Source of Contributions	Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from the Employer, contributions by the employee, or will be shared by the Employer and the employee. The cost of Medical, Prescription Drug, Dental and Vision coverage is shared by the Employer and employees enrolled in those coverages. The Employer generally pays 100% of the cost of the EFAP, Short-Term Disability, Core LTD, Business Travel Accident, Basic Life and AD&D and Basic Dependent Life coverages; however, your division may require you to pay the cost of Core LTD and you will be notified if contributions are required for your coverage. Employees pay 100% of the Supplemental Life, Supplemental Dependent Life, Buy-Up LTD, Supplemental AD&D and contributions to the Health Care and Dependent Care Flexible Spending Account. Where the Employer and employees share the cost of coverage, the Employer will contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. The Employer in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract or administrative services contract shall be applied first to reimburse the Employer for its contributions, unless otherwise provided in that group insurance contract, administrative service contract or required by applicable law.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

Magna International of America, Inc. reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Magna International of America, Inc.

reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Magna International of America, Inc. also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Magna International of America, Inc. will be approved by its Board of Directors, a duly appointed committee or an authorized officer in accordance with its normal procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Magna International of America, Inc., the Plan shall terminate unless the Plan is continued by a successor to Magna International of America, Inc. or another affiliate of Magna International Inc.

PLAN ADMINISTRATION

Magna International of America, Inc. is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. Magna International of America, Inc. has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Magna International of America, Inc. will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Magna International of America, Inc. will be liable in any manner for any determination made in good faith.

Magna International of America, Inc. may designate other organizations or persons to carry out specific fiduciary responsibilities for Magna International of America, Inc. in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Magna International of America, Inc. will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

POWER AND AUTHORITY OF THE INSURANCE COMPANY

The Vision, Life, Dependent Life, Supplemental Life, AD&D, Supplemental AD&D, EFAP, Business Travel Accident, Core LTD and Buy-Up LTD benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Magna International of America, Inc. and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the

insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not Magna International of America, Inc.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan; and
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.
- The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets 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 any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan 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 (if any) 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 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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.

APPENDIX A — BENEFIT BOOKLETS

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as “Benefit Booklets”) provided by the insurance companies and Claims Administrators.

The Benefit Booklets are intended to describe the benefits available to you as an employee of Magna International of America, Inc. or a participating Employer, and, when read with this summary, are intended to meet ERISA’s SPD requirements.

Please see the Benefit Booklets for details of Plan benefits.

For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

Coverage	Benefit Booklet Name
Medical	Member Handbook for employees of Magna International of America, Inc. Member Handbook for employees of Magna Mirrors of America, Inc.
Prescription Drug	Pharmacy Benefit Overview
Dental	Certificate of Coverage
Vision	Evidence of Coverage
Basic Life Insurance	Your Certificate of Insurance
Supplemental Life Insurance	Your Certificate of Insurance
Basic and Supplemental Dependent Life Insurance	Your Certificate of Insurance
Short Term Disability	“Your Benefit Plan” Booklet
Core Long-Term Disability	Your Certificate of Insurance
Buy-Up Long-Term Disability	Your Certificate of Insurance
Accidental Death and Dismemberment	Your Certificate of Insurance
Supplemental AD&D	Your Certificate of Insurance
Business Travel Accident	Your Certificate of Insurance

APPENDIX B — ADDITIONAL INFORMATION ABOUT THE LOOKBACK METHOD

GLOSSARY OF DEFINED TERMS RELATED TO THE LOOKBACK METHOD

Break in Service. A Break in Service occurs when you do not have an Hour of Service for a period of 13 consecutive weeks or longer. The Plan Administrator, at its discretion, may also determine whether you have had a Break in Service using the Rule of Parity. Under the Rule of Parity, you will be considered to have had a Break in Service if you have a period of at least four weeks (up to 13 weeks) during which you do not have an Hour of Service, if the period without an Hour of Service is greater than your immediately preceding period of employment.

Hours of Service. Hours of Service means any hour for which you are paid, or entitled to payment, for (1) the performance of duties for the Employer, or (2) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of Service for salaried employees and hourly employees are based on actual hours worked. An Hour of Service does not include:

- Hours for which your compensation is considered non-US source income;
- Hours worked as a volunteer;
- Hours worked as part of a Federal Work-Study Program.

An hour of overtime counts as one hour of service, regardless of the rate you are paid.

Initial Administrative Period. Initial Administrative Period means the period (of no longer than 90 days) beginning immediately after the end of the Initial Measurement Period and ending immediately before the start of the Initial Stability Period. The Initial Measurement Period also includes the period between a new employee's date of hire and the beginning of the Initial Measurement Period, if the Initial Measurement Period begins later than the new employee's date of hire.

Initial Measurement Period. Initial Measurement Period means the period beginning on the first of the month following your start date and ending 12 months later.

Initial Stability Period. Initial Stability Period means the 12-month period beginning on first of the month following 13 consecutive months after your date of hire

Minimum Value. A plan that meets minimum value standards pays at least 60% of the total allowed costs of benefits provided under the plan.

New Employee. You are considered a New Employee for purposes of the Lookback Eligibility Definition if you did not work for the entire Standard Measurement Period before the plan year.

New Full-Time Employee. If you are regularly scheduled to work at least 30 hours per week at the time of hire or when you return to work after a Break in Service, the Employer will classify you as a New Full-Time Employee for purposes of Medical benefits.

New Part-Time Employee. If you are regularly scheduled to work less than 30 Hours of Service a week at the time of hire or after a Break in Service, the Employer will classify you as a New Part-Time Employee for purposes of Medical benefits.

Seasonal Employee. If the Employer hires you in a position customarily six months or less, beginning at approximately the same time annually, the Employer will classify you as Seasonal for purposes of Medical benefits.

Special Unpaid Leave. Special Unpaid Leave means unpaid leave subject to the FMLA, USERRA, or on account of jury duty.

Standard Administrative Period. Standard Administrative Period means the period (of no longer than 90 days) beginning immediately after the end of the Standard Measurement Period and ending immediately before the Standard Stability Period begins.

Standard Measurement Period. Standard Measurement Period means the 12 month period beginning each October 13th and ending the next year on October 12th. An Employee's Hours of Service are determined by excluding any period of Special Unpaid Leave during the Standard Measurement Period and applying that average for the entire Standard Measurement Period.

Standard Stability Period. Standard Stability Period means the plan year immediately following the end of a Standard Measurement Period.

Variable Hour Employee. If the Employer can't reasonably know when you are hired or when you return to work after a Break in Service whether you will average at least 30 Hours of Service per week over the Initial Measurement Period, the Employer will classify you as a Variable Hour Employee. Interns and co-op students are classified as Variable Hour Employees.

APPENDIX C – SPECIAL RULES RELATING TO COVID-19

This Appendix C is a supplement to the Plan that applies during the duration of the COVID-19 public health emergency period declared by the Department of Health and Human Services (“HHS”) on January 31, 2020. Unless indicated otherwise, these rules will expire with the termination of the COVID-19 public health emergency period on May 11, 2023.

Health Care Flexible Spending Account Rules

Participants in the Health Care Flexible Spending Account are permitted to carry over unused balances from 2020 to 2021, and to carry over unused balances from 2021 to 2022.

If you terminated employment in 2020 or 2021, you may be reimbursed for claims incurred following your termination date and before the last day of the Plan Year (December 31) from any remaining payroll contributions credited to your account.

Dependent Care Flexible Spending Account Rules

Participants in the Dependent Care Flexible Spending Account are permitted to carry over unused balances from 2020 to 2021, and to carry over unused balances from 2021 to 2022.

Additionally, the claims period for a dependent who “ages out” by turning 13 years old during the COVID-19 public health emergency is extended. The limiting age is 14 for 2021 but this only applies to Dependent Care Flexible Spending Account funds that remained unspent at the end of 2020.

Mid-Year Election Changes

You are allowed to change your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account election at any time in 2021, even if you did not otherwise experience a change in status event.

Coverage for COVID-19 Testing

Coverage for in vitro diagnostic testing to detect SARS-CoV-2 (including testing to detect antibodies against SARS-CoV-2) or diagnose COVID-19, and the administration of these tests at no cost:

- That are approved by the FDA;
- For which the developer has asked for or intends to request FDA emergency-use approval, until FDA approval of the test is denied or the developer does not timely request authorization;
- That are developed in states that have informed the Department of Health and Human Services (HHS) of their intention to review COVID-19 tests; and
- That are determined by HHS to be appropriate.

Coverage also is provided for items and services furnished during an office visit (whether in-person or using telehealth, and including facility fees), urgent care center visit, or emergency room visit that results in an order for or administration of COVID-19 testing. These items and services are covered only to the extent they relate to screening you or a covered spouse or dependent to determine if testing is needed, or for providing or administering a COVID-19 test.

Coverage also is provided for:

- At-home and point-of-care testing.
- Testing at state-administered or locality-administered sites.

For individuals who receive multiple COVID-19 tests, coverage will be provided for each test and related items and services, as medically appropriate.

Coverage for COVID-19 Preventive Services

The provisions in this subsection are not limited to the duration of the COVID-19 public health emergency.

The Welfare Benefit Plan will cover at no cost all immunizations/vaccines for COVID-19 with a recommendation that makes them qualifying coronavirus preventive services under the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”), without cost-sharing, even if the vaccines are not listed for routine use on immunization schedules issued by the CDC. This includes the related administration of the vaccines, and any other “qualifying coronavirus preventative service” under the CARES Act as an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either:

- An evidence-based item or service that has in effect a rating of “A” or “B” in the current U.S. Preventive Services Task Force recommendations.
- An immunization that has in effect a CDC/Advisory Committee on Immunization Practices recommendation regarding the individual involved, whether or not the immunization is recommended for routine use.

Certain Plan Deadlines Extended During Outbreak Period

Under Department of Labor regulations, the period from March 1, 2020, until 60 days after the announced end of the COVID-19 national emergency (or such other date announced by the Department in future guidance) is disregarded for all Plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in calculating certain benefit-related timeframes. This is referred to as the “outbreak period.” The Federal government has announced that the COVID-19 national emergency will end on May 11, 2023, which means that the outbreak period will end on July 10, 2023. Thus, the special rules described in this Appendix will no longer apply to Plan deadlines for events occurring after July 10, 2023, and the deadlines in the SPD will control.

The outbreak period is limited to:

- One year from the date the Plan participants, beneficiaries, qualified beneficiaries, or claimants were first eligible for relief; or
- 60 days after the announced end of the COVID-19 national emergency (July 10, 2023).

COBRA Continuation Coverage

Your right to continued group health plan coverage under COBRA is described in the SPD. The Welfare Benefit Plan will disregard the outbreak period for determining the following deadlines for participants or qualified beneficiaries:

- The 60-day period for electing COBRA.
- The due date(s) for making COBRA premium payments.
- The date for individuals to notify the Plan of a COBRA qualifying event or disability determination.

So, for example:

- A COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2021, then the deadline for making the election was delayed until February 28, 2022.
- A COBRA qualified beneficiary would have been required to make a COBRA election by December 1, 2022, then the deadline for making the election is delayed until September 8, 2023, which is the earlier of December 1, 2023, or the 60 days after the end of the outbreak period (60 days after July 10, 2023).

HIPAA Special Enrollment Period

HIPAA special enrollment rights allow you to enroll yourself and/or your dependents in Medical and Prescription Drug coverage following certain circumstances.

- If you (or your dependents) lose other medical or prescription drug coverage or when a person becomes your dependent by birth, adoption, placement for adoption or marriage, you generally have 31 days to enroll in the Plan's Medical and Prescription Drug coverage.
- If you lose eligibility for coverage under a state Medicaid or CHIP program, or if you become eligible for state premium assistance under Medicaid or CHIP, you generally have 60 days to enroll in the Plan's Medical and Prescription Drug coverage.

The Welfare Benefit Plan will disregard the outbreak period for purposes of calculating the 31 or 60-day HIPAA special enrollment period.

Benefit Claim and Appeals Deadlines

The SPD describes the benefit claim and appeal deadlines that apply to those Plan benefits that are covered by ERISA. The following deadlines are impacted:

- The Plan will disregard the outbreak period for determining the deadline by which benefit claims have to be submitted and appealed.
- The Plan will also disregard the outbreak period for determining the deadline by which a Participant must file or perfect a request for external review of a medical benefits claim.

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