HBC U.S. Health and Welfare Plan

Plan Document and Summary Plan Description

Adopted as of January 1, 2016

ADDITIONAL INFORMATION ABOUT YOUR PLAN

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Hudson's Bay Company ("HBC") maintains various employee benefit programs for employees and their dependents of certain Participating Employers that would each separately constitute an "employee welfare benefit plan" within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"). In order to simplify the administration of these programs, HBC has combined each of these programs into a single plan to be known as the HBC U.S. Health and Welfare Plan (the "Plan"). Each such benefit coverage shall automatically be included as part of the Plan, unless specifically excluded by HBC (each such included coverage referred to hereinafter as a "Coverage").

This Document, together with the applicable insurance policies, certificates of coverage, summaries of coverage or other component benefit plan descriptions (each a, Coverage Document), serve as both the official plan documents and as the summary plan descriptions for the benefits provided under the Plan. This Plan is intended for Eligible U.S. Associates of HBC affiliates designed herein as Participating Employers, which are listed in Exhibit 1. You can request Coverage Documents at no charge through the HBC Benefits Department or directly from each Contract Administrator. Coverage Documents are also available for download on HBC's benefits website, MyHBCBenefits.com.

Except as otherwise noted herein, if any conflict arises between this Document and the Coverage Document as applicable to the specific benefit, the Coverage Document will control first, followed by this Document.
HBC reserves the right to amend this Plan at any time or from time-to-time without the consent of any Associate or Participant. Although HBC expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any plan feature or component at any time without liability.

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SECTION 1

INTRODUCTION

1.1 Description of the Plan. The HBC U.S. Health and Welfare Plan ("Plan") is an ERISA plan. The Plan is sponsored by Lord and Taylor Acquisition Inc. ("Plan Sponsor") for Eligible U.S. Associates of HBC and Participating Employers, and their Eligible Dependents. Plan Sponsor has contracted with third parties to administer the Benefit Programs through a number of different arrangements. The Plan is a "consolidated" plan because the Benefit Programs offered are all under one ERISA plan. The following benefits are made available through the Plan:

- Medical Benefits
- Prescription Benefits
- Health Care Flexible Spending Accounts, Including Limited Purpose HFSA
- Dental Benefits
- Vision Benefits
- Employee Assistance Program
- Basic Term Life and Accidental Death and Dismemberment Insurance
- Supplemental Term Life and Accidental Death and Dismemberment Insurance
- Spouse/Domestic Partner Term Life Insurance
- Child(ren) Term Life Insurance
- Long Term Disability Insurance

1.2 Your Benefits Under the Plan. Plan Benefits for medical and prescription benefits (other than in Hawaii and Puerto Rico, which are fully insured) are provided on a self-funded basis, which generally means benefits are paid out of the Participating Employer's general assets. Plan Sponsor is the Plan Administrator for self-funded benefits but has contracted with third parties to assist with administration, including to act as Claims Fiduciaries, where applicable. Other benefits, such as life, disability, dental and vision insurance, are provided through fully insured group plans and are administered by the group insurance carrier. The third parties who perform administrative services for Plan Sponsor are called Contract Administrators in this Plan, and are listed in Exhibit 1.

SECTION 2

DEFINITIONS

2.1 Coverage Document means the applicable insurance policies, certificates of coverage, coverage summaries or other component plan documents that describe the Benefit Programs, each of which are incorporated into this document.

2.2 Benefit Program or Benefit Programs means the group health and welfare benefit program(s) offered through the Plan. Collectively, the Benefit Programs may also be referred to as the **Benefit Plans**.

2.3 Claim Fiduciary means the named fiduciary having the authority and responsibility to adjudicate claims in accordance with the provisions of a specific Benefit Program. In the event of a member appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered.

2.4 Code means the Internal Revenue Code of 1986, as amended.

2.5 Contract Administrator means the third parties, including insurance issuers that provide services to one or more of the Benefit Plans, including claims processing and other administrative services, which are listed in Exhibit 1.

2.6 Covered Person means a Participant or an Eligible Dependent who is covered under a Benefit Program pursuant to Section 3.

2.7 Eligible Dependent means, subject to the terms and conditions of the applicable Benefit Program, an Eligible Employee's dependent that meets the criteria set forth in Section 3.2.

2.8 Eligible Employee means those employees of the Participating Employer that meet the criteria described in Section 3.1 and any additional criteria consistent with the rules of Proposed Treasury Regulation 1.125-1(g).

2.9 Employee Contribution means the amount paid by a Participant for the employee's share of the premium, equivalent premium rate or cost allocated towards purchase or provision of a benefit under the Plan for the Participant and any covered dependents.

2.10 Employer Contribution means the amount paid by the Participating Employer for its share of the premium or cost allocated towards purchase or provision of a benefit under the Plan for a Participant and any covered dependents.

2.11 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

2.12 Group Health Plan means only the medical, prescription, dental, vision, employee assistance, and wellness group plans provided under the Plan.

2.13 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.14 Participant means an Eligible Employee who is covered under a Benefit Program pursuant to Section 3.

2.15 Participating Employer means Plan Sponsor and any of its subsidiaries or affiliates which are (i) members of a controlled group of corporations within the meaning of Code Section 414(b) of which the Plan Sponsor is a member; (ii) members of a group of trades or businesses under common control within the meaning of Code Section 414(c) of which the Plan Sponsor is a member, or (iii) members of an affiliated service group within the meaning of Code Section 414(m) or (o) of which the Plan Sponsor is a member, and which participate with the approval of the Plan Sponsor, have adopted this Plan and are listed herein as a Participating Employer in Exhibit 1.

2.16 Plan means the HBC U.S. Health and Welfare Plan, as it may be amended from time to time.

2.17 Plan Administrator means Lord and Taylor Acquisition Inc. and/or its designee.

2.18 Plan Document and Wrap SPD means this document together with the applicable Coverage Documents, as they may be amended from time to time.

2.19 Plan Sponsor means Lord and Taylor Acquisition Inc. and/or its designee.

2.20 Plan Year means the twelve-month period beginning on each January 1 and ending on each December 31.

2.21 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

SECTION 3

PARTICIPATION

3.1 EMPLOYEE ELIGIBILITY.

Subject to the provisions below concerning the Group Health Plan that provides medical coverage, the Coverage Documents describe who is eligible to participate, as well as the requirements for enrollment, waiting periods, if any, and when coverage commences. In order to participate in all Benefit Plans, you must timely complete the applicable enrollment process, submit your enrollment and satisfy any other enrollment requirements, including providing any required dependent documentation. The Plan Administrator or its designee, or an administrator of claims has the right to request information needed to determine or confirm an individual's eligibility for benefits under this Plan.

Subject to the terms in the applicable Coverage Document, an employee generally is considered an active employee or actively at work for purposes of administering the benefits plans (including making eligibility determinations) referenced in this booklet if the employee is present and capable of carrying out the assigned job duties. In addition, for purposes of enrollment determinations under a Group Health Plan and to the extent required under HIPAA, employees who are absent from work due to a health factor will be considered actively at work.

Medical plan eligibility. Medical plan coverage eligibility determinations under the Plan will be made in a manner consistent the final regulations issued by the Internal Revenue Service on February 10, 2014, implementing the employer responsibility provisions of the Affordable Care Act (ACA) under section 4980H of the Internal Revenue Code, and subsequent regulatory guidance concerning those regulations, as amended, and consistent with the Participating Employers' administrative guidelines. Note, however, that eligibility for coverage under the component medical, dental and vision plans in Hawaii and Puerto Rico shall be governed by the applicable Coverage Documents for those components.

In general, Participating Employers will follow an initial measurement period, look-back or other measurement periods established under the applicable administrative procedures to determine whether certain classes of employees are meeting the average hours of service per week in order to be eligible under the medical plan. If an employee meets the average hours of service requirement during the applicable initial, look-back or other measurement period, he or she will be offered coverage for the corresponding stability period. In most cases, the determination of whether an employee is a full-time employee for a stability period will remain during that period regardless of the number of hours of service the employee is credited with during that period. However, if an employee ceases to be credited with an hour of service for a period of 13 weeks of longer, upon return to work he or she will be treated as a new employee.

You are **not** eligible for coverage under the Benefit Plan(s) if:

- You are an individual whose terms of employment are subject to a collective bargaining agreement that does not provide for participation in the Plan;

- You are a leased employee;
- You are an individual whose compensation is not treated by a Participating Employer at the time of payment as being subject to payroll tax withholding (i.e., contract employees) or you are an independent contractor or other self-employed individual. In either case, such classification shall remain valid for Plan purposes even if a court or administrative agency determines you to be a common law employee.

Classification, reclassification, or retroactive classification of an individual's status by any other entity (even a court or government agency) will not cause the individual to become an Eligible Employee for purposes of this Plan or the Benefit Plan(s).

3.2 DEPENDENT ELIGIBILITY

Regardless of the benefit type or enrollment type, an Eligible Dependent may not be enrolled for coverage under the Plan unless the Eligible Employee is a Participant or will become a Participant in connection with such enrollment.

To be eligible for coverage under the Benefit Plan(s), an Eligible Employee's or Participant's dependent must meet the definition of an Eligible Dependent under the applicable Benefit Plan in which the Eligible Employee or Participant is enrolled, as described in the applicable Coverage Documents.

In general, an Eligible Dependent includes only:

(a) An Eligible Employee's or Participant's legally married spouse, civil union partner or domestic partner as defined in the applicable Benefit Plan and declared as such on the HBC Marriage, Civil Union or Domestic Partnership Certification signed as a condition of benefit enrollment;

(b) Each natural or adopted child or stepchild of (i) an Eligible Employee or Participant, or (ii) the Eligible Employee or Participant's legally married spouse, civil union partner or domestic partner as defined in the applicable Benefit Plan, if such child or stepchild is otherwise eligible under the applicable Benefit Plan.

Benefits under this Plan are not available beyond the age of 26 except to the extent specifically provided for under a specific Benefit Program.

For Group Health Plans only, eligibility for a child may continue beyond twenty-six (26) years of age if the Eligible Dependent child is mentally handicapped/challenged or physically handicapped/challenged and was enrolled as a covered dependent under the Group Health Plan Benefit as of the date twenty-six (26) years is attained, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Contract Administrator upon request, and additional proof may be required from time to time.

An Eligible Dependent does not include a spouse, civil union partner or domestic partner of the Eligible Dependent child or a child of the Eligible Dependent child.

For purposes of the Plan, "child" shall be deemed to include (i) a child for whom a qualified medical child support order is in effect, under which coverage under a Benefit Program is required, (ii) a child who has been placed for adoption with the Eligible Employee or Participant and (iii) a child for whom the Eligible Employee or Participant has been appointed guardian before the age of 19 by a United States court of competent jurisdiction, provided that such child is supported entirely by the Eligible Employee or Participant or the Eligible Employee's or Participant's spouse, civil union partner or domestic partner and permanently resides in the Eligible Employee or Participant's household. For fully insured plan benefits (e.g., life and disability benefits), "child" shall be deemed to include any other child if and to the extent that applicable state law (if not preempted by ERISA) requires that such child be treated as the dependent child of the Eligible Employee or Participant for purposes of coverage.

If you have questions regarding eligibility, contact the Human Resources Department.

3.3 INITIAL ENROLLMENT

If you are a newly Eligible Employee, you must enroll for coverage within thirty-one (31) days following your hire date or initial eligibility date, as applicable. The Coverage Documents describe the requirements for enrollment, waiting periods, if any, and when coverage commences. You may enroll yourself and, if applicable, your Eligible Dependents. Dependents may not participate in any Benefit Program unless the Eligible Employee has enrolled for the benefit (i.e. is a Participant). Generally, coverage will become effective on the first day of the month coincident with or next following your completion of 60 days of service, provided you have timely completed the applicable enrollment requirements. If you are a newly Eligible Employee and you choose not to enroll or fail to properly enroll in the Group Health Plans, you will only be automatically enrolled in the following Benefit Programs:

- Basic Term Life;
- Basic Accidental Death and Dismemberment;
- Core Long-Term Disability (applicable to Salaried Eligible Employees only); and
- Employee Assistance Program (EAP) (applicable to all Eligible Employees and their Eligible Dependents).

3.4 Annual ENROLLMENT ELECTION PERIOD

An annual enrollment election period will be provided for the Benefit Plans. During the annual enrollment period, you will have the opportunity to select your enrollment levels for the next year. Initial enrollment in the Benefit Plan must be completed using applicable enrollment forms. The Plan Administrator may thereafter require enrollment on an annual basis or may allow enrollment to roll over if you were enrolled in certain Benefit Plans in the previous year. If enrollment is allowed to roll over, then you do not need to make any changes to your enrollment selections during annual enrollment because your enrollment selections will remain the same as the prior year. If roll over is not allowed, you will need to enroll using the applicable

forms as required by the Plan Administrator. You will be notified of the required enrollment process at the time of each annual enrollment.

3.5 CHANGE IN STATUS SPECIAL ENROLLMENT RIGHTS

Once you have enrolled, you will not be able to change your coverage selections until the next annual enrollment period, unless you have a qualified Change in Status. To make an election change due to a Change in Status you must submit an Enrollment/Change form and any other required documentation to the Plan Administrator no later than 31 days following the Change in Status event; provided, however that for Change in Status events that relate to Medicaid or State Children's Health Insurance Program (SCHIP) coverage eligibility, the Enrollment/Change form and any other required documentation must be submitted to the Plan Administrator no later than sixty (60) days following the Change in Status event. Currently, the Plan considers the following events to be a Change in Status:

- Marriage, Domestic or Civil Union Partnership, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including acquiring a new dependent by marriage, birth, adoption, placement for adoption, or losing a dependent due to death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status/election, such as moving out of an HMO coverage area for medical insurance;
- HIPAA Special Enrollment Events (see below);
- You or a dependent become newly eligible for Medicaid or SCHIP coverage; or
- You or a dependent have Medicaid or SCHIP coverage which is terminated as a result of a loss of eligibility.

There are detailed rules on when a change in election is deemed to be consistent with a Change in Status. For more information, refer to the Section 125 Cafeteria Plan document. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If any of these conditions apply to you, you should contact The HBC Benefits Service Center.

If the cost of coverage under a Benefit Program increases significantly during the Plan Year, you may also revoke your election and obtain coverage under another Benefit Program with similar coverage, if available, or revoke your coverage election entirely.

If the benefits provided under a Benefit Program are significantly curtailed during a Plan Year, then you may be permitted to revoke your elections and elect to receive on a prospective basis

coverage under another Benefit Program with similar coverage. In addition, if the Plan Sponsor adds a new Benefit Program option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated). There are also certain situations when you may be able to change your elections or may elect a benefit plan on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

An Employee covered under the medical plan who experiences a reduction in hours of service because of a change in position from full-time to part-time may revoke medical plan coverage if the following two (2) requirements are satisfied: (i) the Employee has been in an employment status under which the Employee was reasonably expected to average at least 30 hours of service per week under the terms of the medical plan and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than 30 hours of service per week after the change, regardless of the effect of the change on medical plan eligibility; and (ii) the Employee's election to revoke medical plan coverage corresponds to the Employee's intent to enroll the Employee and then-covered family members, if any, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

3.6 HIPAA SPECIAL ENROLLMENT EVENTS

If you gain the right to enroll in the Group Health Plans or to add coverage for an Eligible Dependent under the special enrollment rights of HIPAA, you may revoke a prior election to forego coverage and make a new election. A HIPAA special enrollment right due to loss of other coverage is available to you if you meet all of the following requirements:

- You must otherwise be eligible for coverage under the Group Health Plan.
- You must have been covered under another group health plan or must have had other health coverage.
- You must have declared in writing at the time you initially declined coverage under the Group Health Plan that you already had other coverage.
- If the other coverage was COBRA continuation coverage, COBRA continuation coverage was exhausted.
- If the other coverage was not COBRA continuation coverage, you lost eligibility for that other coverage or the Participating Employer stopped contributions for that other coverage.

The loss of eligibility must not be due to failure to pay the applicable premiums or for cause (such as making a fraudulent claim). Special Enrollment is also available when you acquire a new Eligible Dependent through marriage, Domestic or Civil Union Partnership, birth, or adoption or placement for adoption. Your request to enroll the new Eligible Dependent must be made no later than 31 days following the date the new dependent is acquired ("qualifying event") and you must timely complete the applicable enrollment requirements. If you have previously declined to enroll, you may enroll yourself and your Eligible Dependent when you marry, enter into an eligible Domestic Partnership or acquire a new child as a result of birth, adoption or placement for adoption.

Coverage under this Special Enrollment provision for newly acquired dependents with respect to marriage or Domestic or Civil Partnership will be effective on the date of marriage or the date you and your domestic or civil union partner satisfy the applicable eligibility requirements, provided the applicable enrollment requirements are satisfied.

In the case of newborn and adopted children, any Eligible Dependent child born or adopted while you are covered under a Group Health Plan will be covered from birth or placement for adoption, respectively, for a period of 30 days from the date of birth or adoption, regardless of when you enroll the child. This special rule does not however, apply under the dental or vision plan. To continue coverage beyond the 30-day period after the child's birth or adoption, you must request special enrollment no later than 31 days after the birth or adoption/placement for adoption of the child and timely complete the applicable enrollment requirements. If timely notice is not given, in addition to terminating coverage for the child effective as of the end of the 30-day period described above, the applicable Group Health Plan may charge a fee to cover the 30-day period of coverage provided from the child's date of birth or placement for adoption.

If the Plan Administrator receives a request to add an Eligible Dependent under special enrollment more than 31 days after the qualifying event, or the applicable enrollment requirements are not completed, coverage will not be provided; in the case of a newborn or adopted child, coverage will not be extended beyond the 31-day period described above. Instead, the next opportunity to enroll the Eligible Dependent will generally be during the next annual enrollment period or a subsequent special enrollment period.

Special enrollment rights also exist under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an eligible employee or eligible dependent child –

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or
- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

To enroll under this provision, he must request enrollment within 60 days after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

SECTION 4

BENEFIT CLAIMS AND APPEALS PROCEDURE

If your claim for benefits under a Benefit Plan is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures. You may request a review of the denied claim, which will require you to specify your reasons for requesting the review of the denied claim. For additional details, including how much time you have to submit your request and where to submit your request, please refer to the applicable Coverage Documents furnished by the Contract Administrator(s) for the Benefit Plan(s) in which you are enrolled. Additionally, for general information, you may also refer to the applicable Claims Procedures section at the end of this Plan Document and Wrap SPD.

SECTION 5
ADDITIONAL BENEFITS AND RIGHTS

5.1 BENEFITS DURING FAMILY AND MEDICAL LEAVE, PREGNANCY DISABILITY LEAVE, OR OTHER PROTECTED LEAVES

If you are on a leave of absence approved by your Participating Employer and your leave is protected under the federal Family and Medical Leave Act (FMLA), or any state or local law not preempted by ERISA, you may continue your Group Health Plan coverage (i.e., medical, dental, vision and EAP benefits) for a period of time during such leave of absence. You may also continue your life, disability, and accidental death and dismemberment insurance coverage, see below for more details.

While you are on approved protected leave, your Participating Employer will continue to pay the Employer Contribution (for individual or dependent coverage) in accordance with state and federal laws and your Participating Employer's policy on leaves of absence. **NOTE**: You must continue to pay your regular Employee Contribution if you want to continue Group Health Plan coverage during an approved leave. Please contact the Human Resources Department for more information on continuing Group Health Plan coverage under the Plan during a leave of absence.

Benefits that are not continued during an approved leave (if you choose not to pay your regular Employee Contribution) will be reinstated, with no waiting period or preexisting condition limitation, if any, when you return from protected leave.

NOTE: Basic Life Insurance, Basic Accidental Death & Dismemberment (AD&D) and Long Term Disability (LTD) coverages remain in effect during an approved leave, as set forth in the applicable Coverage Documents, provided you continue to pay any applicable Employee Contribution.

Contact the Human Resources Department for additional information on the family/medical or pregnancy disability leave policies or if you want to request leave under state or local family leave law.

5.2 CONTINUING BENEFITS DURING MILITARY LEAVE

We will grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), and applicable state law. In general, during such a leave of absence under USERRA, you may be eligible to elect to continue group health plan coverage for yourself and your enrolled dependents (if any) for up to 24 months.

More specifically, if you are absent from work for more than (thirty) 30 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see below, as of the first day of your absence for such duty. This means that in addition to having the option to elect to continue coverage under COBRA, you will become eligible to elect continuation coverage under USERRA using procedures similar to those required by COBRA. The Plan Administrator or its designee will furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your right to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator and providing payment of any required contribution for the health coverage. The election procedures are same as for COBRA; refer to the COBRA section below for more information. However, only the covered employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage. The employee's spouse and dependent children do not have independent election rights under USERRA. This means that if the employee does not elect continuation coverage under USERRA, his spouse, for example, still may elect continuation coverage under COBRA, but not USERRA. If you do not make your election within 60 days of being provided with the notice mentioned above, you will no longer be eligible to continue coverage under the Plan, except as required by USERRA.

The required contribution will include the amount we normally pay on your behalf if the period of continuation coverage is fewer than 31 days. If not, the required premium will be 102% of the full premium for the level of coverage elected. Premium payments must be made in the same time and manner as those required under COBRA.

If you elect to continue coverage under USERRA, the period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Continuation coverage under USERRA will end, however, upon the first to occur of the following: (i) the last day of the 24 month coverage continuation period, (ii) the last day of the period for which timely premium payment is made, (iii) you fail to return to work within the time frame required under USERRA following the completion of your service, or (iv) you lose your rights under USERRA as a result of dishonorable discharge or other conduct under USERRA.

Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, your health coverage for you and your enrolled dependents (if any) will be reinstated under the Plan as required under USERRA. No exclusions or waiting period may be imposed on you or your enrolled dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Contact Human Resources for more information regarding your rights under USERRA to continue coverage, as well as reemployment and other rights you may have under USERRA.

5.3 PAID LEAVE OF ABSENCE

If you take a paid leave of absence (whether under the USERRA, the FMLA, or otherwise), your Employee Contribution for Benefit Plan coverage, as applicable, will continue to be collected through payroll deductions during the period of the leave for which you are eligible for continued group coverages. If your salary continuation during the leave is not sufficient to cover Employee Contribution deductions, you must make arrangements with your Participating Employer to pay your Employee Contribution on a monthly basis (e.g., personal check).

5.4 UNPAID LEAVE OF ABSENCE

If you take an unpaid leave of absence (whether under the USERRA, the FMLA, or otherwise), you must make arrangements with your Participating Employer to pay your Employee Contribution on a monthly basis (e.g., by personal check) during the period of the leave for which you are eligible for continued group coverages.

If you take an unpaid leave of absence, you also are entitled to revoke your benefit elections. In that case, your participation in the Plan ends, and you do not make any Employee Contributions during your leave.

5.5 LEAVES OTHER THAN FMLA OR USERRA

Other leaves of absence shall be administered in accordance with your Participating Employer's policy on leaves of absence, subject to the provisions in the Plan. Please contact the Human Resources Department for more information on continuing coverage under the Plan during a leave of absence.

5.6 COBRA CONTINUATION RIGHTS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows Plan participants to continue Group Health Plan coverage under specified circumstances where such group health coverage would otherwise be lost. See COBRA Continuation Coverage Rights, included on Appendix A attached hereto for details on your COBRA rights and obligations.

5.7 MATERNITY MINIMUM STAY PROVISIONS

The Newborns' and Mothers' Health Protection Act (NMHPA) generally prohibits group health plans offering the group health insurance coverage from:

- Restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.
- Requiring that a provider obtain authorization from the group health plan for prescribing a length of stay not in excess of the above periods.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and Contract Administrators may not, under federal law, require that a provider obtain authorization from the Plan or the Contract Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5.8 COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

The Women's Health and Cancer Rights Act requires group health plans to make certain benefits available to Covered Persons who have undergone a mastectomy. When a Covered Person has had a mastectomy (at any time) and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles that apply to other Plan benefits:

- 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 in all stages of mastectomy, including lymphedema.

This coverage is subject to applicable deductibles, co-payments and co-insurance payments, and to the terms and provisions of the applicable group health plan. If you have any questions about your benefits under the Plan, call the Customer Service number on your group medical ID card or contact the Human Resources Department.

5.9 QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents get divorced. When a Participating Employer receives a QMCSO, the Plan Administrator must promptly notify the employee and the child that the order has been received and what procedures the Plan Administrator will use to determine if the order is "qualified." The Plan Administrator or its designee, in its sole discretion, shall determine whether an order or notice qualifies as a QMCSO in accordance with the procedures it has established for such purpose. If the Plan Administrator determines the order is qualified and

the employee must provide coverage for his/her child pursuant to the QMCSO, the Participating Employer will deduct from the employee's paycheck the amount necessary to pay for such coverage. The Plan Administrator will notify the affected employee once it determines whether or not the order is qualified. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator without charge.

If a QMCSO requires your spouse, your former spouse, or another individual to provide coverage for your dependent child, and that coverage is, in fact, provided, you may cancel coverage under the Plan for that child within thirty-one (31) days following the effective date of the other coverage by contacting the Human Resources Department.

SECTION

PLAN RIGHTS

6.1 RIGHTS OF RECOVERY

The Plan is not intended to provide a Covered Person with benefits greater than those due under the terms of the Benefit Programs. For example, the Plan is not intended to pay more in benefits under a Group Health Plan than the amounts of covered medical expenses incurred by Covered Persons, after the applicable cost sharing provisions have been applied. These subrogation and reimbursement rights shall be subject to any Coverage Documents. If a Covered Person is entitled to payment of medical, dental, vision or other expenses by another person, plan, or entity, whether or not the Covered Person requests payment or not, the Plan has the right to reduce its payments accordingly so that you and your dependent are not paid more than actually owed. If you or your dependent has a right against any other person, firm, or organization for an injury or illness, or any complication thereof, the Plan has the right to subrogate all benefits that have been paid, or that will be paid, by the Plan because of the illness or injury, or any complications thereof. If the Plan considers such benefits are the responsibility or liability of a third party, the Plan has the right to recover any benefits paid.

If benefits are paid under the Plan and you or your dependent later obtains a recovery, you or your dependent are obligated under the terms of the Plan to reimburse the Plan for the benefits paid. To the extent permitted by law, the Plan shall be reimbursed in full for benefits paid, regardless of whether you or your dependent has been "made whole" or fully compensated for damages by any responsible person or third party alleged to be legally responsible to you or your dependent, and regardless of whether medical, dental, vision or other expenses are itemized in a payment or award, or how claims are classified or categorized by the parties to the dispute, the court or any other third party.

Such recovery will be available from any liable person ("Third Party"), including but not limited to:

- The persons and entities, either individually or collectively, causing an injury, illness or other loss for which the Plan had or may provide benefits;

    - Third Party Insurance;
    - No-fault or personal injury protection ("PIP") insurance;
- Financial responsibility or catastrophe funds mandated by motor vehicle or other state law;
    - Uninsured or motorist under-insured insurance;
- Motor vehicle reimbursement insurance, regardless of whether or not it is purchased by you or your dependent; or
- Homeowner's insurance and other premises insurance, including reimbursement coverage.

Reimbursement due the Plan shall not be subject to or limited by any proration formula that takes into account the relationship between the amount of damages claimed by you or your dependent and the amount of recovery received by you or your covered dependent, whether by settlement, judgment, insurance proceeds or in any other manner, nor shall it be subject to or limited by any reduction of any recovery of payment due to you or your dependent's or any Third Party's fault or negligence.

You and your dependent must cooperate with the Plan Administrator and the Contract Administrator in assisting it to protect its legal rights under these subrogation provisions. The Plan maintains both a right of reimbursement and a separate right of subrogation. You and your dependent must do nothing to prejudice the Plan's rights under this provision, either before or after the need for services or benefits from the Plan. You and your dependent are obligated to immediately inform the Contract Administrator of any illness or injury of you or your dependent for which a claim for damages may be made against any Third Party. You and your dependent shall acknowledge that the subrogation right and reimbursement right of the Plan shall be considered the first priority claim against any Third Party, to be paid on a first-dollar basis before any other claims which may exist are paid, including claims by you or your dependent for general damages.

The payment of benefits under the Plan is conditioned upon the Plan's right of reimbursement from the proceeds of any recovery received by or payable to you or your dependent, whether by settlement, judgment, insurance proceeds, or otherwise. The Plan may, at its discretion, take such action as may be necessary and appropriate to preserve its rights, including placing a lien against any Third Party recovery to the extent of the benefits paid by the Plan for the subject illness or injury, bringing suit on behalf of you or your dependent, or intervening in any lawsuit involving you or your dependent related to the illness or injury. The Plan may, at its discretion, require the assignment of you and your dependent's right of recovery, up to the extent of benefits provided under the Plan. The Plan or Contract Administrator may initiate any suit against you and your dependent or the legal representative of the same to enforce the terms of the Plan. Any proceeds collected, held or received by you or your dependent, legal representative, or any other party to whom such proceeds may be paid by virtue of a settlement of, or judgment relating to, any claim of you or your dependent that arises from the same event to which payment by the Plan is related, are constructively held in trust for the benefit of the Plan and for satisfaction of the Plan's subrogation right and/or reimbursement right. Once settlement is reached, the Plan Administrator or the Contract Administrator will require copies of all court documents and/or

settlement agreements. Benefits will then be adjudicated according to the rules of Coordination of Benefits (see Section 6.3 below).

Once the Contract Administrator determines that Third Party liability may be involved with a claim, you and/or your dependent may be asked to sign a repayment agreement, protecting the Plan against any loss where other parties may be responsible. If a repayment agreement is requested, the Plan's right of recovery through reimbursement or subrogation remains in effect regardless of whether the repayment agreement is actually signed and returned. The Plan Administrator, in its discretion, may instruct the Contract Administrator to continue payment of benefits while the liability of a party other than you and/or your dependent is being legally determined. A violation of the repayment agreement is considered a violation of the terms of the Plan.

If you or your dependent should directly receive payment from or on behalf of any Third Party, you and your dependent are required to immediately reimburse the Plan on a first dollar basis the full amount of benefits paid by the Plan, up to the aggregate amount recovered from or on behalf of each Third Party. Except to the extent permitted by the Contract Administrator pursuant to nondiscriminatory rules established by the Contract Administrator in its discretion, the Plan will not pay attorney fees or costs associated with your or your dependent's claim or lawsuit, or offset any recovery or in any way be responsible for any fees, costs or expenses associated with pursuing a claim or lawsuit, unless it consents in writing to make such payment. To the extent permitted by applicable law, amounts due the Plan under this Section may be applied against any other present or future benefits (and thereby reduce such benefits) payable under the Plan to or on behalf of you or any of your covered dependents, regardless of whether such benefits are related to the subject illness or injury.

6.2 ASSIGNMENTS TO PROVIDERS

Except as otherwise provided in the Coverage Documents, benefits due to any service provider will be considered "assigned" to such provider when a provider bills the Plan for the services and payment will be made directly to the provider, whether or not a written assignment of benefits was executed and filed with the Plan.

Except as otherwise provided in the Coverage Documents, the Plan will also pay the provider directly for services when the Covered Person has signed an assignment of benefits or requested that the provider submit the medical bills to the Plan on the Covered Person's behalf (if the Contract or Plan Administrator requests proof of assignment, the Contract Administrator may withhold payment of benefits until such proof is supplied). If a custodial parent submits bills for reimbursement to the Plan, the Plan may make benefit payments for a child covered by a QMCSO directly to the custodial parent or legal guardian of the child. Duplicate payment will not be made to both a provider and Covered Person or to a custodial parent and Participant for the same service.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Participant or

Covered Person as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

If you are Medicare eligible, or become Medicare eligible, refer to your Coverage Documents to determine primary and secondary payor.

If the Plan Administrator or a Contract Administrator finds that any person entitled to receive benefits under the Plan is unable to care for his or her affairs due to physical illness, infirmity, or mental incompetence, or because the person is a minor, any benefits or payments owed to such person may be paid to the person's legal representative or custodian, or to a spouse, child, parent, or other caretaker for such person, or may be directly applied for the person's welfare, support, and maintenance, as the Plan Administrator or Contract Administrator deems advisable.

6.3 COORDINATION OF BENEFITS

The Plan contains a provision called "Coordination of Benefits" (COB). This feature coordinates benefits from all group plans covering you or your dependents to prevent duplication of benefit payments. The COB provision sets out rules for the order for payment of covered charges when two or more plans are paying. When you or your dependent is covered by the Plan and another plan, the plans will coordinate benefits when a claim is received. The COB provision of the Plan shall be administered in accordance with the Coverage Documents.

Generally, COB will be administered as follows:

- A plan that covers a person other than as a dependent will be primary to a plan that covers such person as a dependent;
- A plan that covers a person as a dependent of an employee whose date of birth occurs earlier in a calendar year will be primary to a plan that covers such person as a dependent of an employee whose date of birth occurs later in a calendar year (only month and day of birth, not year shall be reviewed in this case);
- In the case of dependent child whose parents are separated or divorced:
  - when the parent with custody of the child has not remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a dependent of the parent without custody; and
  - when the parent with custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a stepparent, and the plan that covers the child as a dependent of the stepparent will be primary to the plan that covers the child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which establishes financial responsibility for the medical expenses of the child, the plan that covers the child as a dependent of the parent with such responsibility will be primary to any other plan that covers the child as a dependent.

When the rules stated above do not determine an order of benefit determination, the plan that has covered a person for the longer period of time will be primary, provided that the plan that covers the person as a laid-off or retired employee, or as a dependent of such an employee will be secondary to any plan that covers such person as an active employee or as a dependent of such an employee.

SECTION 7

PRIVACY RIGHTS

Use and Disclosure of Protected Health Information (PHI)

The Group Health Plans will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A, D and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

Use and Disclose PHI as Permitted by Authorization of a Participant

As soon as practicable following the receipt of an authorization from a Covered Person or his or her duly appointed personal representative, the Group Health Plans will disclose PHI in accordance with the authorization or as allowed by applicable law without authorization.

Disclosure to the Plan Sponsor

Upon request of the Plan Sponsor, the Group Health Plans will disclose summary health information and enrollment and disenrollment information to the Plan Sponsor as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Group Health Plans will disclose to the Plan Sponsor PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration" as defined in the HIPAA Privacy Rule only upon receipt of a certification from the Plan Sponsor that the Group Health Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this section.

To receive PHI as described in the preceding paragraph, the Plan Sponsor shall certify to the Group Health Plans that it agrees to:

- not use or further disclose PHI other than as permitted or required by the Group Health Plan documents or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Group Health Plans;

- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Group Health Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Group Health Plans any security incident, as defined under the HIPAA Security Rule, or any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with the access requirements under the HIPAA Privacy Rule;
- make PHI available for amendment and incorporate any amendments to PHI in accordance the HIPAA Privacy Rule;
- make available the information required to provide an accounting of disclosures in accordance with the HIPAA Privacy Rule;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Group Health Plans available to the HHS Secretary for the purposes of determining the Group Health Plans' compliance with the HIPAA Privacy Rule; and
- if feasible, return or destroy all PHI received from the Group Health Plans that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

Adequate Separation Between the Group Health Plans and the Plan Sponsor Must Be Maintained

In accordance with the HIPAA Privacy Rule and the HIPAA Security Rule and to the extent permitted under the Group Health Plans' privacy policies, only the following employees or classes of employees may be given access to PHI:

- Privacy and Security Officer.
- Designated members of the Human Resources, Payroll, Finance/Accounting Departments, if any.
- Designated members of the Information Technology Department.
- Designee(s) of the Privacy and Security Officer, if any.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this Plan document, and the Plan's policies and procedures, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

SECTION 8

AMENDMENT AND TERMINATION OF THE PLAN

The Plan and any component Benefit Plan may be amended or terminated by the Plan Sponsor at any time for any reason in its sole discretion. The Plan Sponsor may decrease or eliminate the Employer Contribution towards benefit plan costs, subject to any applicable legal requirements for prior notice. No consent shall be necessary for the Plan Sponsor to amend or terminate the Plan or any Benefit Program.

In the event of the Plan's termination, the rights of all persons covered by the Plan at the time shall be limited to claims incurred prior to the date of the termination. Benefits provided under the Plan are not vested benefits. No employee, officer, or director of the Plan Sponsor has the authority to alter, vary or modify the terms of the Plan or any component Benefit Plan except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan or a component Benefit Plan, or its written amendments, shall be binding upon the Plan, the Plan Administrator, or Plan Sponsor.

A termination or amendment of any of the Benefit Plans will not cause any Covered Person or beneficiary to be retroactively deprived of any benefit paid or in payment status as of the date of the termination or amendment. If the Plan Sponsor terminates a Benefit Plan (or Benefit Program), the Plan Sponsor will not make further Employer Contributions, or any other funding, to that Benefit Program and no rights to benefits shall exist under the terminated Benefit Program on and after the date of termination. If a benefit is eliminated under any of the Benefit Programs, no person will be eligible to receive that eliminated benefit on or after the effective date of the elimination of the benefit and Employee Contributions cease.

SECTION 9

STATEMENT OF ERISA RIGHTS

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 all Plan participants shall be entitled to:

9.1 RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the

latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual financial report.

9.2 CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the Group Health Plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this Wrap SPD and the documents governing the applicable group health plan(s) on the rules governing your COBRA continuation coverage rights.

9.3 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Participating Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health/welfare benefit or exercising your rights under ERISA.

9.4 ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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.

No action at law or in equity may be brought to recover under the Plan until all of the Plan's mandatory appeal levels, including review by an independent review organization which the Plan has included as part of the mandatory appeal processes for medical benefits, have been exhausted and the Plan benefits requested have been denied in whole or in part. No lawsuit shall be brought against the Plan, Plan Administrator, or Plan Sponsor after 90 days from the date of the independent review organization's determination.

9.5 ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan or a Benefit Program, you should contact the Human Resources Department or the appropriate Contract Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 10

10 CLAIMS PROCEDURES IN GENERAL

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor regulation, 29 CFR § 2560.503-1, and ERISA and the Affordable Care Act. For information about the procedures for the filing and processing of claims and appeals of adverse determinations on claims, refer to the applicable Coverage Documents. Where any provision is in conflict with the Department of Labor's claims procedure regulations, ERISA, or any other applicable law, such law shall control. You should first file a claim with the appropriate Contract Administrator listed below in Section 11 and in accordance with the procedures required by that Contract Administrator. If your claim is denied, or if you believe that you are entitled to a larger benefit, then you may file an appeal with the Contract Administrator.

No action at law or in equity may be brought to recover under the Plan until all of the Plan's mandatory appeal levels, including review by an independent review organization which the Plan has included as part of the mandatory appeal processes for medical benefits, have been exhausted and the Plan benefits requested have been denied in whole or in part. No lawsuit shall be brought against the Plan, Plan Administrator, or Plan Sponsor after one year from the date of the independent review organization's determination.

ADDITIONAL LEVELS OF APPEAL

Subject to the Contract Administrator's established procedures, up to two (2) voluntary additional levels of appeal (including arbitration or any other form of dispute resolution) are permitted, but only after exhaustion of the Plan's mandatory appeal procedures. A Claimant cannot be required to pursue any voluntary level of appeal and a voluntary level of appeal cannot stop the Claimant from filing suit. The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to pursue a voluntary level of appeal. Any statute of limitations or other defense based on timeliness is tolled (suspended) while a voluntary appeal is in process or pending.

NOTE: Arbitration is permitted as a level of appeal, but only if the Claimant is provided with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if Claimant agrees to such arbitration after completing the internal appeal process. Mandatory arbitration is permitted only as a mandatory appeal level. However, a Claimant is not precluded from challenging the decision under Section 502(c) of ERISA or other applicable law.

Section 11

SUMMARY OF PLAN INFORMATION

NAME OF PLAN:	HBC U.S. Health and Welfare Plan
PLAN SPONSOR, PLAN ADMINISTRATOR and PARTICIPATING EMPLOYERS:	**Plan Sponsor** Lord and Taylor Acquisition Inc. 225 Liberty Street New York, NY 10281 (646) 802-7114 **Plan Administrator** Lord and Taylor Acquisition Inc. 225 Liberty Street New York, NY 10281 (646) 802-7114 The Plan Administrator has full and discretionary authority and power to administer and construe the terms of the Plan and the component Benefit Plans. This authority includes, without limitation, the discretion: • to make such rules, regulations, interpretations, and computations and to take other such actions to administer the Plan and each component Benefit Plan as it deems necessary or appropriate; • to decide any dispute which may arise regarding the rights of Covered Persons under the Plan and each component Benefit Plan, including the authority to decide all questions concerning the Plan, including questions of fact respecting Plan benefits, the eligibility of any person to participate in a Plan and the status and rights of any Covered Person under the Plan; and • to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan and each component Benefit Plan. To the extent permitted by law, the Plan Sponsor shall indemnify each employee of the Plan Sponsor with duties concerning a component Benefit Plan against expenses (including any amount paid in settlement of claims) reasonably incurred by him or her in connection with any claims against him or her by reason of

	his or her conduct in the performance of his or her duties with respect to a component Benefit Plan, except in relation to matters resulting from willful misconduct, breach of good faith, or gross negligence in the performance of those duties. The preceding right of indemnification shall be in addition to any other right to which any such employee may be entitled as a matter of law or otherwise. **Participating Employers (Other than Plan Sponsor): See Exhibit 1.** • Lord & Taylor, LLC • Saks Fifth Avenue LLC • Gilt (to be effective January 1, 2017)
AGENT FOR SERVICE OF LEGAL PROCESS:	Corporation Service Company 2711Centerville Road Suite 400 Wilmington, DE, 19808 Service of legal process may also be made on the Plan Administrator
EMPLOYER IDENTIFICATION NUMBER:	99-0372181
PLAN NUMBER:	501
TYPE OF PLAN:	The Plan is an employee welfare benefit plan. The benefits are not insured by the Pension Benefit Guaranty Corporation, as that program does not apply to welfare benefit plans. The component welfare benefits provided under the Plan include: Life, Accidental Death & Dismemberment, Additional (Optional) Term Life, Medical, Prescription, Dental, Vision, Health Flexible Spending, Long Term Disability (LTD), , and Employee Assistance Program (EAP).
END OF PLAN YEAR:	December 31
TYPE OF ADMINISTRATION:	For component Benefit Plans provided through insurance, the insurance company (and not Plan Sponsor or Plan Administrator) is responsible for deciding whether a benefit is payable and paying the actual benefit to which Covered Persons may be entitled. The insurance company providing such benefits has the full discretionary authority to interpret plan terms, to determine benefit eligibility and to make sure that claims are paid according to the provisions of the certificate of coverage and applicable law. Such determinations shall be final and conclusive on all persons claiming such benefits. For component Benefit Plans that are self-funded by the Plan Sponsor, (e.g., the medical plan) initial claims and first level

	appeals of adverse benefit determinations will be reviewed and adjudicated by the Contract Administrator. In some cases, the Plan Administrator may maintain final discretionary authority to interpret Plan provisions and determine benefit claims, unless that function has been delegated to the Contract Administrator. For medical claims, a Covered Person may request review by an Independent Review Organization (IRO) after all Plan appeal processes are exhausted. A decision obtained through the IRO process will be final. The applicable Contract Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and interpretation of the respective component Benefit Plan. This includes, without limitation, the power to construe any applicable administrative services agreement, to determine all questions arising under the plan, to resolve the claims, complaints and appeals of Covered Persons and to make, establish and amend the rules, regulations and procedures with regard to the component Benefit Plan. The Plan Administrator and Contract Administrator shall be entitled to rely upon (a) any tables, valuation, computations, estimates, certificates and reports furnished by another Contract Administrator or any consultant, or firm or corporation that employs one or more consultants, and (b) any opinions furnished by legal counsel. The Plan Administrator shall be fully protected and shall not be liable in any manner whatsoever for anything done or action taken or suffered in reliance upon any such information, opinions or reports. Any and all things done or actions taken or suffered by the Plan Administrator shall be conclusive and binding on all employees and any other persons whomsoever, except as otherwise provided by law. The Plan Administrator and any Contract Administrator may, but are not required to, rely upon all records of the Plan Sponsor with respect to any matter or thing whatsoever, and may likewise treat those records as conclusive with respect to all employees and any other persons whomsoever, except as otherwise provided by law. However, the Plan Administrator and Contract Administrator may not rely on oral or written communications where a reasonable and prudent administrator would reasonably investigate further to confirm the information or communication.
CONTRACT ADMINISTRATORS	See Exhibit 1
PLAN CONTRIBUTIONS AND FUNDING:	Employees who participate in one or more of the Benefit Plans offered under the Plan may be required to make Employee Contributions to the Plan for coverage. The Plan Sponsor, in its sole and absolute discretion, shall determine the amount of any required Employee Contributions under the Plan and may increase or decrease the amount of the required contribution at any time. The Plan Sponsor may require different contribution

	levels for different classes of employees. The Plan Sponsor will notify Eligible Employees as to what the Employee Contribution rates will be. Any experience credits or refunds under a group health contract shall be applied first to reimburse the Plan Sponsor for its contributions, unless otherwise provided in that group health contract or required by applicable law.
LOSS OF BENEFITS:	Circumstances under which you may be disqualified from the Plan, ineligible for benefits, or have benefits denied, forfeited, suspended are outlined in the Coverage Documents provided by the Plan Administrator or the Contract Administrator for the Benefit Program(s) in which you are enrolled.
PROCEDURE FOR AMENDING THE PLAN:	The Plan may be amended or terminated by the Plan Sponsor at any time. The Plan Sponsor may decrease or eliminate its Employer Contributions towards Plan costs, subject to any applicable legal requirements for prior notice. No consent shall be necessary for the Plan Sponsor to amend or terminate the Plan. In the event of the Plan's termination, the rights of all persons covered by the Plan at the time shall be limited to claims incurred as of the date of the termination. Benefits provided under the Plan are not vested benefits. No employee, officer, or director of a Participating Employer has the authority to alter, vary or modify the terms of the Plan or any Benefit Program. No verbal or written representations contrary to the terms of the Plan or a Benefit Program, or its written amendments, shall be binding upon the Plan, the Plan Administrator, or a Participating Employer.
COLLECTIVELY BARGAINED EMPLOYEES	The Plan does not provide benefits to collectively bargained employees except to the extent the collective bargaining agreement expressly provides for participation in the Plan.
LIMITATION OF RIGHTS	You nor your covered dependents, beneficiaries, or other persons shall acquire, by reason of the Plan, this Wrap SPD, or any other Plan document, any right in or title to any assets, funds or property of any Participating Employer. No employee, officer, director or agent of any Participating Employer guarantees in any manner the payment of Plan benefits.
NO EMPLOYMENT RIGHTS	The Plan does not confer employment rights on any person. No person shall be entitled, by virtue of the Plan, to become or to remain in the employ of a Participating Employer, and nothing in the Plan shall restrict the right of a Participating Employer to terminate the employment of any Eligible Employee or other

	person at any time.
INFORMATION YOU MUST PROVIDE	You must provide your Participating Employer or the Plan Administrator as applicable with such documents, data or other information as they consider necessary or desirable for administering the Plan. You may also be required to fully complete forms, releases or documents as necessary. The benefits payable under the Plan to you or on your behalf are conditioned on furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan. Failure to submit accurate information can result in your termination of coverage under the Plan or disciplinary action up to and including termination of employment.

APPENDIX A – COBRA CONTINUATION COVERAGE

In General

It is important that all covered individuals take the time to read this information carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide the covered dependent's name and address to the Human Resources Department so a notice can be sent to him or her as well.

Under federal COBRA law, most employers are required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This section is intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under the Continuation Coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, the Plan Administrator will send you additional information and the appropriate election notice at that time. The information described in this section replaces any discussion of COBRA continuation coverage contained in the insurance certificate or benefit booklet and is only intended to provide COBRA continuation coverage to the extent required by law; provided however that if the plan provides coverage for domestic or civil partners, COBRA Continuation Coverage will be provided to the extent provided under the terms in the insurance certificate or benefit booklet.

Qualifying Events

Qualifying Events for Covered Employee – If you are the covered employee, you may have the right to elect COBRA Continuation Coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

*Qualifying Events for Covered Spouse** – If you are the covered spouse of a covered employee, you may have the right to elect COBRA Continuation Coverage for yourself if you lose group health coverage under your spouse's employer's group health plan(s) because of any of the following reasons:

- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your spouse.
- Divorce or, if applicable, legal separation from your spouse.
- Your spouse becomes entitled to Medicare.

*Qualifying Events for Covered Dependent Children** – If you are the covered dependent child of a covered employee, you may have the right to elect Continuation Coverage for yourself if you lose group health coverage under your parent's group health plan because of any of the following reasons:

- A termination of your parent's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your parent (the covered employee).
- Your parents divorce or, if applicable, legally separate.
- Your parent (the covered employee) becomes entitled to Medicare.
- You cease to be a covered dependent under the terms of the Plan.

* **Important – Required Employee, Spouse, and Dependent Notifications**. Under the law, covered individuals, including the employee, spouse, or other family member, have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status. This notification must be made within 60 days after the later of the date on which the qualifying event occurs or the date on which a qualified beneficiary loses or would lose coverage as a result of the qualifying event. You must provide this notice by mail or personal delivery to COBRA Administrator listed in Exhibit 1. This notice must identify: (i) qualified beneficiaries and their respective addresses, phone numbers and dates of birth, (ii) the qualifying event, (iii) the date the qualifying event occurred, (iv) include evidence supporting the occurrence of the qualifying event acceptable to the COBRA Administrator; and (v) the name of the plan under which you are losing coverage and the level of coverage at the time of the event. For example, in the case of a Social Security Disability, the notice must include a copy of the Social Security Administrator's determination of disability.

If notification is not completed according to the Plan Administrator's procedures and within the required 60-day notification period, then rights to Continuation Coverage will be forfeited. Carefully read the applicable dependent eligibility rules so you are familiar with when a dependent ceases to be a covered dependent under the terms of the applicable benefit.

Electing COBRA Coverage

Election Period and Coverage. Once the Plan Administrator learns a qualifying event has occurred, the Plan Administrator will notify covered individuals (also known as qualified beneficiaries) of their rights to elect Continuation Coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect Continuation Coverage. The 60-day election window is measured from the later of the date of COBRA notification on or after the qualifying event or the date coverage is lost. This is the maximum period allowed to elect COBRA. If a qualified beneficiary does not elect Continuation Coverage within this election period, then rights to continue coverage under the applicable Plan will end and he or she ceases to be a qualified beneficiary.

To elect Continuation Coverage, you must complete the applicable election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect Continuation Coverage. For example, the covered employee's spouse may elect Continuation Coverage even if the covered employee does not. Continuation Coverage may be elected for only one, several, or for all covered dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any covered dependent children. The covered employee or his or her spouse can elect Continuation Coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

If, during the election period, a qualified beneficiary waives Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of Continuation Coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date that they are sent to the Plan Administrator, or its designee for COBRA administration.

Length of Continuation Coverage

18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Extension for Social Security Disability. The 18-month coverage period described above may be extended for 11 months if you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. To receive this extension, you must notify the Plan Administrator of the disability determination within 60 days after the latest of the following events: (i) the date of the Social Security Administration's disability determination; (ii) the date on which the qualifying event occurs; or (iii) the date coverage is or would be lost as a result of the qualifying event; provided the notice is not made later than your initial 18-month period of Continuation

Coverage. You must provide this notice by mail or personal delivery to COBRA Administrator listed in Exhibit 1, and that notice must include all of the information, as applicable, described above in the paragraph entitled, "Important – Required Employee, Spouse, and Dependent Notifications" under the "Qualifying Events" Section.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension.

Note, it is also the qualified beneficiaries' responsibility to notify the Plan Administrator within 31 days if a final determination has been made that they are no longer disabled. In this case, you are required to notify the Plan Administrator of this change in disability status in the manner described above.

Extension for Secondary Events. Another extension of the 18-month or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of Continuation Coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a Covered Dependent). If a second event occurs, then the original 18 or 29 months of Continuation Coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiaries' responsibility to notify the Plan Administrator or its designee in writing by mail or personal delivery within 60 days of the second event and within the original 18 or 29-month COBRA timeline. You must provide this notice by mail or personal delivery to COBRA Administrator listed in Exhibit 1, and that notice must include all of the information, as applicable, described above in the paragraph entitled, "Important – Required Employee, Spouse, and Dependent Notifications" under the "Qualifying Events" Section.

In no event, however, will Continuation Coverage last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for Continuation Coverage. A reduction in hours followed by a termination in employment is not considered a second event for COBRA purposes.

36 Months. If the original event causing the loss of coverage was the death of the covered employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a covered dependent child under the Plan, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

The maximum coverage period for a qualified beneficiary who is the spouse or dependent child of the retired covered employee ends 36 months after the death of the retired covered employee.

Coverage Options, Cost, and Timing of Payments

A Participating Employer is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA covered individuals. Should coverage change or be modified for non-COBRA covered individuals, then the change and/or modification will be made to your coverage as well.

If a qualified beneficiary elects Continuation Coverage, he or she will be required to pay the entire cost for the coverage, plus a 2% administration fee. Note that the cost for Continuation Coverage provided during the disability extension will increase to 150%. If you elect Continuation Coverage, you must make your first payment for Continuation Coverage not later than 45 days after the date of your election. Such payment must include all of the periodic premium payments that have accrued to the date of the payment. If you fail to make your first payment for Continuation Coverage in full before the end of the 45-day period following the date of your election, you will lose all Continuation Coverage rights under the Plan and COBRA.

After you make your first payment for Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, each of these periodic payments for Continuation Coverage is due on the first day of the coverage period. However, you will be given a grace period of 31 days after the first day of the coverage period to make each periodic payment. Your Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to Continuation Coverage under the Plan and COBRA.

Eligibility and Potential Conversion Rights

A qualified beneficiary does not have to show he or she is insurable to elect Continuation Coverage, however, he or she must have been actually covered by the Plan on the day before the qualifying event to be eligible for COBRA Continuation Coverage. An exception to this rule is if while on Continuation Coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the Plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Contact the Plan Administrator for the procedures and timelines for adding these individuals. The Plan Administrator reserves the right to verify COBRA eligibility status and terminate Continuation Coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

At the end of the 18, 29, or 36 months of Continuation Coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under the group health plan if an individual conversion plan is available at that time.

Special rules for qualified beneficiaries in a health flexible spending arrangements.

COBRA continuation coverage under the Plan will be made available when coverage would otherwise end because of a qualifying event described above provided that:

- at the time of the qualifying event the covered employee was a participant in the Plan; and

- the remaining balance in the covered employee's account available for reimbursement under the Plan exceeds the amount of premium payments he or she would be required to make to such account for the remainder of the Plan Year in which the qualifying event occurred.

Note, however, that upon the occurrence of a qualifying event where the above conditions are satisfied, a qualified beneficiary may not establish a new account under the Plan under COBRA. Instead, as illustrated by the following examples, a qualified beneficiary may only elect COBRA continuation coverage in the account originally established by the covered employee.

> ***Example 1***: Assume Employee A is married and enrolled in the Plan, electing to contribute $1,200 to his account for 2016. After seven months in the plan, Employee A made no requests for reimbursement under the Plan but has contributed $700 to his health flexible spending account (HFSA) through payroll deductions. Employee A's employment is terminated on the last day of the seventh month in the Plan. Because Employee A experienced a qualifying event and because the amount available to Employee A under his HFSA ($1,200) is greater than the amount of premium contributions he would have to make for the remainder of the Plan Year ($500), COBRA continuation coverage will be made available for the remainder of the Plan Year.
>
> If Employee A elects COBRA continuation coverage with respect to his HFSA, his spouse may continue to have her expenses reimbursed under the HFSA; however, she may not elect to establish her own account under the Plan.
>
> ***Example 2***: Using the same facts as in Example 1, if Employee A chooses not to elect to continue his HFSA coverage under COBRA, his spouse may elect to do so provided she makes a timely election and pays the applicable COBRA premiums. The same would also be true if Employee A died, for example, instead of being terminated from employment.

Notwithstanding anything contained in this section, COBRA continuation coverage under the Plan may not continue beyond the end of the Plan Year in which the qualifying event occurred.

Special rules for employees eligible for trade adjustment assistance. The Trade Act of 2002 created a new tax credit for certain eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. In addition, these employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their Plan coverage ended. If you have questions about

these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Early Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end prior to the maximum continuation period for any of the following reasons:

- The Company ceases to provide any group health plan to any of its employees.
- Any required premium for Continuation Coverage is not paid in a timely manner.
- A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.
- A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare.
- A qualified beneficiary extended Continuation Coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled.
- A qualified beneficiary notifies the Plan Administrator he or she wishes to cancel COBRA Continuation Coverage.
- For cause, on the same basis that the Plan terminates the coverage of similarly situated non-COBRA participants.

Notification of Address Change. To ensure all covered individuals receive information properly and efficiently, it is important that you notify the Plan Administrator and the COBRA Administrator of any address change as soon as possible. Your failure to do so may result in delayed COBRA notifications or a loss of Continuation Coverage options.

Any Questions?

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your actual COBRA rights at that time. If any covered individual does not understand any part of this summary notice, or has questions regarding the information or his obligations, please contact the COBRA Administrator.

In addition, for more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's

Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

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Exhibit 1

CONTRACT ADMINISTRATORS

BENEFIT OR SERVICE	*INSURER/VENDOR INFORMATION*
ENROLLMENT AND ELIGIBILITY ADMINISTRATOR	HBC Benefits Service Center c/o Univers Workplace Solutions 897 12th Street Hammonton, NJ 08037 Phone number: 1-800-498-8705 Fax number: 1-610-362-8587 Website: www.myHBCbenefits.com
MEDICAL BENEFIT CLAIM ADMINISTRATOR AND DENTAL BENEFIT INSURER	Cigna Health and Life Insurance Company ("Cigna") Policy number(s): 3339027 (Saks) 2499844 (L&T) 2500146 (Gilt) Cigna PO Box 182223 Chattanooga, TN 37422 Phone number: 1-855-281-1206
PRESCRIPTION BENEFIT ADMINISTRATOR	CVS Health / CaremarkPCS Health, L.L.C. Policy number: 0106 CaremarkPCS One CVS Drive Woonsocket, RI 02895 Phone Number: 1-888-202-1652

VISION BENEFITS	Insurer: VSP® Vision Care Policy: 30059856 Vision Service Plan Attn: Customer Service P.O. Box 997100 Sacramento, CA 95899-7100 e-mail address: imember@vsp.com or online link: https://www.vsp.com/contact-email.html phone number: 1-800-877-7195
DISABILITY INSURER AND CLAIM ADMINISTRATOR	Cigna Life Insurance Company of New York Group Policy: NYK-980014 Cigna 140 East 45th Street New York, NY 10017-3144 (800) 732-1603
GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE CARRIER (Basic, Supplemental, Spouse and Child Life and AD&D)	Insurer: MetLife Policy # 151333 Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505 phone number: 1-800-638-6420
EMPLOYEE ASSISTANCE PROGRAM ("EAP") VENDOR	Optum Employee Assistance Program (EAP) phone number: 866-248-4094 Website: liveandworkwell.com
COBRA ADMINISTRATOR	Connect Your Care Contract (s): 134910 307 International Circle, Suite 200 Hunt Valley, MD 21030 phone number: 844-220-8782