Inova Health System
Health Plan for
Retired Employees

Summary Plan Description

January 1, 2023

NOTE: Because this document is only a summary of the Plan, it does not take the place of the Plan document. If there is a conflict between the provisions of the Plan document and this booklet, or if the Plan is required to operate in a different manner to comply with federal laws and regulations, the Plan document or the appropriate federal laws and regulations will control in all cases.

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INOVA HEALTH SYSTEM
HEALTH PLAN FOR RETIRED EMPLOYEES
SUMMARY PLAN DESCRIPTION

Introduction

Inova Health System (the "Company") has established the Inova Health System Health Plan for Retired Employees (the "Plan") to address the health benefits applicable to retired employees (the "Component Benefit Programs") by the Company and its affiliated employers, and to provide uniform administration of those benefits. The benefit options available under the Component Benefit Programs are listed in Exhibit A to this Summary Plan Description. This Summary Plan Description ("SPD") is effective January 1, 2023.

The insurance contracts, plan descriptions, policies and procedures, and any other documents making up the Component Benefit Programs are not affected by the adoption of the Plan and the terms of the Component Benefit Programs will continue to control for purposes of determining your benefits. The terms of the plan descriptions for each Component Benefit Program are incorporated into this SPD by reference and will continue to act as the primary source of information on each Component Benefit Program.

General Information Pertaining to the Plan

Plan Name, Sponsor and Employer Identification Number. The name of the Plan is the Inova Health System Health Plan for Retired Employees. The Plan sponsor is Inova Health System Foundation. The Company's address is Inova Health System Foundation, Attn: Benefits Department, 8095 Innovation Park Dr., Fairfax, VA 22031. The Company's telephone number is (703) 205-2190. The Company's Federal employer identification number (EIN) is 54-1071867.

Plan Year. The Plan Year is January 1st – December 31st.

Plan Number. Each ERISA plan maintained by the Company is issued a plan number for reporting purposes. The number of this Plan is 507.

Type of Health Benefits Plan. The Plan provides health benefits to eligible retired employees under the Component Benefit Programs listed in Exhibit A to this SPD.

Funding. Benefits under the Plan are funded by one or more of the following methods selected by the Company for a Component Benefit Program: insured benefits; self-funded benefits (these are benefits funded by general assets of the Company); or a combination of insured benefits and self-funded benefits.

Plan Administration. The Plan Administrator is the Company, which, with respect to insured benefits offered through the Plan, shares the responsibility for administering the Component Benefit Programs with the insurance companies providing benefits under those Programs. The insurance companies shown on Exhibit A to this document are responsible for considering, accepting or denying, and paying claims for any insured benefits and reviewing appeals of denied insured benefit claims. For self-insured benefits offered under the Plan, the corresponding vendors shown in Exhibit A are responsible for considering, and accepting or denying, the claims for such benefits, as well as reviewing appeals of such benefit claims.

Agent for Service of Process. The Plan Administrator.

Named Fiduciary. The Plan Administrator is the Named Fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Programs. With respect to the determination of the amount of, and

entitlement to, insured benefits under any Component Benefit Program, however, the respective insurance company is also a Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance policy.

Plan Document. The Plan and those documents incorporated by reference constitute a written employee benefit welfare plan as defined by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Eligibility and Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of each Component Benefit Program. Please refer to the relevant retiree health coverage description for a (a) statement of the conditions pertaining to eligibility to receive benefits for each Program, and (b) description or summary of Program benefits. The terms of those documents are incorporated by reference in this Plan.

Plan descriptions addressing each Component Benefit Program for which you are an eligible participant may be obtained directly from the carrier of the plan in which you are enrolled.

In general, you are eligible for benefits under the Plan if you are enrolled in one of the Company's group medical plans under the Inova Health System Health and Welfare Benefits Plan on the last day you were an active employee. Plan benefits depend on continued eligibility and enrollment.

This SPD provides a general overview of eligibility requirements. However, in the event of a conflict between this SPD and the Component Benefit Program, the terms of the applicable Component Benefit Program control.

Bridge to Medicare Plan

Effective January 1, 2024, the Bridge to Medicare Plan will no longer be offered.

Bridge to Medicare Plan benefits for participants who are currently enrolled in the Bridge to Medicare Plan will end on the earlier of the end of the month upon reaching age 65, or December 31, 2023.

Grandfathered Retirees

Grandfathered retirees over age 65 are eligible to enroll in the Aetna Medicare Advantage PPO Plan. All Medicare-eligible retirees and Medicare-eligible dependents must enroll in Medicare Parts A and B. You received written notification in 1993 if you met eligibility criteria for the Medicare Advantage Plan. If you are unsure if you are eligible for this plan, please contact your Human Resources representative or the eServices Center at eservices@inova.org or (703) 205-2166.

To get information about signing up for Medicare Part A and B, contact the Social Security Administration at http://www.ssa.gov or (800) 772-1213 approximately three months before age 65 or within three months before you retire.

Eligible Dependents

The following dependents are eligible for coverage under your retiree benefits as long as they are enrolled in your Inova health plan on your last day of active employment:

- Your legal spouse, domestic partner of either sex (based on requirements for domestic

partnership established by the Plan Administrator) or common law spouse; and

- Your child(ren) up to age 26, or any age dependent who is classified as disabled by the Social Security Administration, whose disability commenced before age 26, who shares the same home with you for more than half of the calendar year and who is primarily dependent on you for financial support. For this purpose, the term "child" includes a biological child, adopted child, step child, foster child, child of a domestic partner, or any other child for whom you, or your spouse or domestic partner, have legal guardianship.

Dependents not covered under your Inova health plan immediately prior to your retirement are not eligible for coverage under the Plan.

If you and your spouse/domestic partner are eligible for retiree benefits, you generally must each maintain your own individual coverage. If your child(ren) work for Inova, they cannot be covered as both a team member and a dependent. Also, you and your spouse/domestic partner cannot both claim your child(ren) as your dependents.

Important Eligibility Notes

- If you drop coverage under the Plan, you will not be able to re-enroll in the Plan, even if you have what might be considered a qualifying event (e.g., divorce, death of a spouse, loss of other coverage, etc.).
- If you drop coverage for your dependent(s), you will not be able to add dependents at a future date unless you have a qualifying event (e.g., marriage, loss of other coverage).
- If your coverage is cancelled due to nonpayment, you will not be able to re-enroll in the Plan.
- Unless you are a Grandfathered Retiree enrolled in the Medicare Advantage benefits, you and/or your dependent(s) are no longer eligible for coverage under the Plan when you and/or your dependent(s) become eligible to receive Medicare benefits under Title XVIII of the Social Security Act and receive notice from the Social Security Administration that Medicare coverage is in effect.

Participation requirements are outlined in the individual Component Benefit Programs and associated plan descriptions.

You may become ineligible for Plan benefits if you fail meet certain requirements of a particular Component Benefit Program. Unless you are a Grandfathered Retiree enrolled in the Medicare Advantage Plan, your coverage under the Plan will terminate when you become eligible for coverage under Medicare.

Benefit Election Rules

If you are a retired employee who is eligible for COBRA continuation coverage under the Inova Health System Health & Welfare Benefits Plan and for retiree benefits under the Plan, you will be given a one-time opportunity to elect COBRA continuation coverage or coverage under the Plan. If you fail to elect to participate in the Plan during the applicable election period (or if you elect COBRA continuation coverage under the Inova Health System Health & Welfare Benefits Plan), you will be deemed to have waived Plan coverage for yourself, your spouse and your eligible dependents.

Making Your Election

When you retire from the Company and become eligible for retiree medical benefits, you must enroll yourself and eligible dependents in the Plan within 31 days after your employment terminates.

The Plan's retiree benefits do not include dental or vision coverage. If you are eligible for dental and/or vision coverage through COBRA, you can elect to continue dental and/or vision coverage for 18 months through COBRA at the same time as electing to participate in the Plan for medical and prescription drug coverage.

Note: if you elect COBRA or do not elect retiree coverage, your decision is permanent and you may not enroll in retiree coverage at a later date.

In making your elections, you may elect and enroll for some or all of the Component Benefit Programs listed under Exhibit A, and you also may elect to cover your spouse and one or more of your eligible dependents if they were enrolled in the Inova Health System Health & Welfare Benefits Plan on your retirement date. Coverage of new Plan participants and any spouse and dependents under the Plan generally will be effective as of the first day of the month following the Retired Employee's termination of employment.

Split Coverage

If you are a grandfathered retiree and your spouse is not eligible for Medicare, your spouse may enroll in the Bridge to Medicare Plan until your spouse is eligible for Medicare, or until December 31, 2023 at which time the Bridge to Medicare Plan will no longer be offered. Your spouse may enroll in the Medicare Advantage plan when they turn 65 if they were covered by an Inova medical plan at the time of your retirement from Inova.

In the event of your death while covered under the retiree insurance, your covered spouse will be allowed to continue the Bridge to Medicare Plan until death, remarriage, Medicare-eligibility, or when the Bridge to Medicare Plan ends on December 31, 2023. If enrolled in the Medicare Advantage Plan at the time of your death, your covered spouse can continue the Medicare Advantage Plan until your spouse's death.

Payment of Premium Cost

If you elect benefits under the Plan, you must pay the monthly premium cost for those benefits, as determined by the Company. The Company may make contributions toward the cost of the benefits provided to you under the Plan. The Company, however, reserves the right to increase, decrease, or eliminate any Company contribution made for any benefits available under the Plan at any time.

The Premium Cost will be due on the first day of the calendar month (or other period) for which coverage under the Component Benefit Program is provided (the "coverage period"). You will have a 30-day grace period for payment of the Premium Cost, beginning with the first day of the applicable coverage period. Your coverage under the applicable Component Benefit Program will terminate if you do not pay the Premium Cost by the last day of the grace period, except as otherwise provided by the Plan Administrator or required by law. Coverage that is terminated for failure to timely pay the applicable Premium Cost cannot be reinstated.

If you are eligible for and enroll in the Bridge to Medicare Plan in 2022 or earlier, the Inova Benefits Center will send you coupons so that you can make your monthly benefit payments. As a retiree, you pay for your benefits on an after-tax basis. As described above, the Bridge to Medicare Plan will no longer be offered beginning in 2024.

If you are eligible for and enroll in the Aetna Medicare Advantage PPO Plan, Aetna will send you an invoice for your monthly benefit payments.

Changing Your Benefits

You generally may not change your benefits elections during the plan year, unless you experience a qualifying event. However, you may elect to drop a benefit at any time. Once you drop a benefit, you may not reelect that benefit later.

If you elect to continue coverage through COBRA, each fall you will receive materials detailing plan changes, rates for the new plan year and information on how to make changes.

Claims Procedures

In general, claims for benefits that are insured or administered by a third party administrator must be filed in accordance with the specific procedures contained in the insurance policies or the third party administrative services agreement. The addresses of (and other contact information for) the individual insurance company and third party administrator that review claims made under a Component Benefit Program are listed in Exhibit A. All other general claims or requests should be directed to the Plan Administrator. This SPD provides an overview of the claims procedures for group health plan claims; to the extent the claims procedures in the Component Benefit Program differ, the Component Benefit Program will control.

NOTE that due to the COVID-19 pandemic, the time periods above for submitting claims and appeals will be extended until the earlier of (1) one year from the deadline that would otherwise apply or (2) 60 days after the end of the declared COVID-19 national emergency. For more information on the extensions, visit www.inova.org/benefits or contact the Plan Administrator.

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are three categories of claims under a Component Benefit Program that is a group health plan and each one has a specific timetable for approval, payment, request for additional information, or denial of the claim. The three categories of claims are:

- *Urgent Care Claim* is a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition may determine if a claim is an Urgent Care claim.
- *Pre-Service Claim* is a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.
- *Post-Service Claim* is a request for payment for covered services you have already received.

Time for Decision on a Claim

In general, you will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. The time deadline for making decisions on health care claims under the Plan depends on the urgency of the claim. The deadlines shown on the chart below are maximum time limits for health care claims.

Time Limit	Urgent Care Health Claim	Pre-Service Health Claim	Post-Service Health Claim
To make initial claim determination	72 hours	15 days	30 days

Time Limit	Urgent Care Health Claim	Pre-Service Health Claim	Post-Service Health Claim
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	15 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request extension of course of treatment	24 hours before expiration of previously approved course of treatment	15 days before expiration of previously approved course of treatment	*Not applicable*
For claimant to request review of denied claim	180 days after date of claim denial		
To make a determination upon review	72 hours	30 days	60 days

Notification of Denial

Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice of the decision on your claim. If your claim is denied, the notice will contain the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial was based;
- A description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary;
- If the claim is for Urgent Care, a description of the expedited review process applicable to such claims;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to pursue the claim in court if it is denied on appeal;
- If the denial is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request;
- If the denial is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request; and
- Any other information required by law.

How to Appeal a Denied Group Health Claim

If your claim is denied, you (or your attorney or other person authorized by you to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal your claim. A failure to timely file an appeal request will constitute a waiver of your right to

request a review of the denial of your claim. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile.

A request for review should be addressed to the claims administrator identified in Exhibit A. A request for review should contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The chart on the prior page, **Time for Decision on a Claim**, describes the period the Plan will follow to review your appeal request and to notify you of its decision.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial denial of your claim. The review will be conducted by someone other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. The reviewer will provide an independent full and fair review of your claim and will give no consideration to the initial adverse determination.

The following rules apply to a benefit denial that is based in whole or in part on a medical judgment, including decisions about whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate:

- The reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- The healthcare professional consulted by the reviewer cannot be the same individual or the subordinate of the individual who was consulted in connection with the original benefit denial; and
- The medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's benefit denial will be identified, even if the advice was not relied upon in making the benefit determination.

You will receive a written notice of the decision on review. If the claim is denied on review, the notice will contain the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial was based;
- A statement that you are entitled to receive, upon request and at no cost, reasonable access to all documents relevant to the claim, and copies of those documents;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A statement of your right to bring a civil action in court;
- If the denial is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request;
- If the denial is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request;

- The statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;” and
- Any other information required by law.

Finality of Determinations

All claims determinations by the Plan Administrator or claims administrator with respect to a benefit claim are final, conclusive and binding. If you wish to preserve your rights to bring a civil action under ERISA section 502(a), you must follow those procedures and file your civil action within one year of the date on which your claim for benefits is denied upon final review. Any legal action brought against the Plan must be filed in a state or federal court within the Commonwealth of Virginia.

Special Notices

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (or QMCSO) is a court judgment, decree, or order (including a court’s approval of a domestic relations settlement agreement) that requires health benefit coverage of your child. The Company’s group health plan will provide benefits required under a QMCSO, to the extent required under ERISA or other applicable law, and will provide benefits to dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants in accordance with applicable law. The Company has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants’ spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborn’s and Mother’s Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women’s Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Please refer to the Plan descriptions

for each Component Benefit Program for the applicable deductible and coinsurance amounts. You can review the Plan descriptions for each Component Benefit Program for which you are an eligible participant at www.inova.org/benefits.

Plan Administration

The Plan Administrator has the express discretionary authority to interpret the terms of the Plan and to decide factual and other questions relating to the Plan and its benefits, including without limitation, factual questions relating to eligibility for, entitlement to, and payment of benefits. The Plan Administrator's reasonable interpretations of the Plan and factual determinations concerning benefit issues are binding. The Plan Administrator may delegate certain administrative or record-keeping functions as it deems appropriate.

Company's Right to Amend or Terminate the Plan

The Company reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Program, in whole or in part at any time. If the Plan or any of the Component Benefit Programs is changed or terminated, your rights to benefits for expenses you actually incurred under a Component Benefit Program in which you were a participant before the change or termination will not be affected.

No Guarantee of Non-Taxability

The Plan provides benefits intended to be non-taxable; however, neither the Plan Administrator nor any fiduciary or other party associated with the Plan will be liable in any way for any taxes or any other liability incurred by you or any person claiming benefits through you.

Relationship to Plan Document

In the event of a conflict between the terms of this Summary Plan Description and the terms of the Plan document and/or policies of Inova, the terms of the Plan document and/or Company policies will prevail.

Reduction in Benefits

You may not receive all of the benefits to which you think you are entitled under the Plan, under the following circumstances:

- You do not qualify as an eligible retiree under the Plan's Component Benefit Programs;
- You have exceeded the limit on a particular service under a Component Benefit Program;
- You fail to timely file a claim for out-of-network benefits under a Component Benefit Program;
- You fail to respond within a reasonable period of time to a request for additional information regarding the processing of a claim under a Component Benefit Program;
- You fail to pre-certify an inpatient admission where required under a Component Benefit Program or otherwise fail to follow the required process or procedures for obtaining Program benefits;
- You fail to make a premium payment as required under a Component Benefit Program;
- Payment for your benefits is being coordinated with another health plan under a Component Benefit Program;
- You may be required to repay the Plan for benefits paid under a Component Benefit Program if you recover monetary damages for an illness or injury caused by a third party;

- You fail to notify the Plan Administrator when a spouse, domestic partner or dependent no longer qualifies as a dependent (through divorce or termination of domestic partnership or age), and are required to repay the Plan for benefits paid under a Component Benefit Program after loss of dependent status;
- The Plan may recover against future Plan benefits any Component Benefit Program benefits that have been overpaid;
- You fail to cash a check for an non-insured benefit within 12 months of the date on the check. Checks not cashed within 12 months will be stopped, the benefit will be forfeited, and the check will not be reissued; or
- The Plan or one or more of its Component Benefits Programs is amended to eliminate specific benefits (although the Plan will, in general, provide coverage for any such benefit services rendered prior to the date of the amendment).

Coordination of Benefits

If you and/or your dependents are covered under another health plan in addition to this Plan, the benefits under this Plan will be coordinated with the other health plan. That means total benefits received under both plans will not exceed the allowable expense under this Plan's Component Benefit Program. One of the health plans will pay benefits first, then the other plan will pay the remaining benefit (if any).

The rules for determining which health plan pays first are applied in the following order:

The health plan that:	Pays BEFORE the health plan that:
does not have a coordination of benefits provision	does have a coordination of benefits provision
has covered the person for the longest period of time	has covered the person for a shorter period of time
covers the person as an employee (or as the dependent of an employee)	covers the person as a laid off or retired employee (or as the dependent of a laid off or retired employee)
covers a person as an employee	covers a person as a dependent

If one or more of your dependents is covered under this Plan and under another parent's or step-parent's plan, and the above rules do not work to indicate which plan should pay benefits first, the plan of the parent or step-parent whose birthday (day and month) falls earlier in the calendar year shall pay first.

When this Plan pays first, benefits will be paid in accordance with the provisions of the Component Benefit Program. When the other plan pays first, benefits will be paid under this Plan only if the amount paid by the other plan is less than the allowable expense under this Plan's Component Benefit Program.

To the extent a Component Benefit Program provides for different coordination of benefit rules, the rules set forth in the Component Benefit Program will supersede the rules as described in this SPD.

Right of Recovery and Subrogation

If the Plan pays medical expenses for you or your covered dependent for an injury or illness that appears to be the fault of someone else or for which you have other coverage (for example, car insurance), you agree to:

- Repay the Plan for such medical expenses from any compensation you receive from, or on behalf of, the person who caused the injury or illness, or your insurance carrier;
- Not settle, without the prior consent of the Plan, any claim that you or your covered dependent may have against any legally responsible party or insurance carrier;
- Give the Plan a lien on any such compensation and hold that compensation in trust for the Plan;
- Promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- Cooperate fully and sign any documents needed to protect the Plan's rights to reimbursement and subrogation, including entering into a subrogation agreement.

Failure to comply with any of these requirements may result in the Plan withholding or reducing payment for further medical, dental or disability benefits.

The Plan has the right to be reimbursed for the full amount of the medical expenses it paid, even if that amount is greater than the settlement you received from, or on behalf of, the person who caused the injury or illness or your insurance carrier. In addition, the Plan is not responsible for any portion of attorney fees or other expenses you are required to pay, and is entitled to reimbursement before any other party that may have a claim on any amounts you recover.

> *For example:* You were injured in a car accident that was caused by another driver. The Plan pays $25,000 in medical expenses resulting from the accident. If you sue the other driver, the Plan has a right to be reimbursed from any settlement you receive. If you receive a settlement of $25,000 or less, the Plan will receive the entire amount, even if you owe a percentage of that amount to your attorney. If you receive a settlement of more than $25,000, the Plan is only entitled to the $25,000 it paid for your medical expenses.

"Subrogation" means that the Plan stands in your place in connection with any settlement or insurance payment you receive. By allowing the Plan to pay for your medical treatment, you agree to protect the Plan's rights in the same way you protect your own rights. The Plan's rights of subrogation and reimbursement apply whether you agree to them in writing or not.

If the Plan has to sue you to receive reimbursement from a settlement or insurance payment you receive, you will be responsible for paying the Plan's collection expenses (including attorneys' fees).

This is a very general "plain English" explanation of the Plan's reimbursement and subrogation rights. Contact the Plan Administrator for a copy of the Plan document and the detailed explanation of the Plan's rights if you think this section may apply to you.

This provision does not limit any other legal remedies the Plan may have. The Plan's rights of subrogation and reimbursement apply regardless of the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Your ERISA Rights

As a participant in the Inova Health System Health Plan for Retired Employees (the "Plan"), you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan and any Component Benefit Program, including insurance contracts, and a copy of the latest annual report (Form 5500) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500) and updated SPDs. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

Enforce Your Rights If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact

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

Exhibit A – Component Benefit Programs

CONTACT INFORMATION FOR
FILING CLAIMS FOR BENEFITS
UNDER THE
INOVA HEALTH SYSTEM
HEALTH PLAN FOR RETIRED EMPLOYEES

Component Benefit Program	Phone Number	Website
Medical (self-insured)* Innovation Health/Aetna Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106	1-800-862-5441	www.aetna.com
Prescription Drug (self-insured)* Express Scripts P.O. Box 52150 Phoenix, AZ 85072	1-877-787-8692	www.express-scripts.com/inovahealthsystem
Medicare Advantage (insured) Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106	1-888-267-2637	www.aetna.com

**Denotes this benefit will not be offered after December 31, 2023.*

Exhibit B - General Notice of Cobra Continuation Coverage Rights

Introduction
You are receiving this notice because you are covered under a group health plan under the Inova Health System Health Plan for Retired Employees (the "Plan"). This notice contains important information about your dependents' rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to your family, and what you need to do to protect the right to receive it.** When your dependents become eligible for COBRA, they may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's SPD or contact the Plan Administrator.

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

NOTE that due to the COVID-19 pandemic, the time periods described in this notice for electing and paying for COBRA coverage, and the time in which you have to notify the Plan of a qualifying event, will be extended until the earlier of (1) one year from the deadline that would otherwise apply or (2) 60 days after the end of the declared COVID-19 national emergency. For more information on the extensions, visit www.inova.org/benefits or contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are the spouse of a retired employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-retired employee dies;
- The parent-retired employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Inova Health System, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan. For this purpose, a qualifying event will arise also if there is a substantial elimination of coverage within one year before or after the commencement date of such proceeding.

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the retired employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

If you are a participant in a group health plan and the qualifying event is the death of the retired employee, the retired employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

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

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. 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.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Non-COBRA Continuation Coverage
Although COBRA coverage applies only to legal spouses and dependents, the Company may decide, in its sole discretion, to extend group health care coverage to domestic partners, civil union partners and the children of such partners who are covered by the group health care plans of the Company. Such continued coverage will be provided under the same terms and conditions as the COBRA coverage described above.

Exhibit C – HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW INOVA'S GROUP HEALTH PLANS MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Introduction
Beginning in 2003, employer health plans became subject to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rules"), as amended. (You can find the Privacy Rules at 45 Code of Federal Regulations, Parts 160 and 164.) The Privacy Rules apply to group health plans, such as Inova's team member and retiree group health plans (referred to herein as the "Health Plan"). The Privacy Rules do not, as a general matter, regulate employers or non-health benefit plans such as workers compensation, disability or life insurance plans. However, employers can be subject to certain requirements of the Privacy Rule in certain cases, as described in greater detail below.

The state in which you live may also impose restrictions on the use and disclosure of your health information that are more stringent than the Privacy Rules. The Health Privacy Project of the Institute for Health Care Research and Policy at Georgetown University maintains information on state health privacy laws at its website, **www.healthinfolaw.org/state**.

This notice is effective May 1, 2021.

Protected Health Information
The Privacy Rules regulate use and disclosure of "protected health information" by the Health Plan. "Protected health information" is information relating to your health condition or your receipt of healthcare, if it contains sufficient data to identify you as the subject of the information. Health information that is merely in summary form and that does not identify you as its subject is not protected health information and may be used or disclosed by the Health Plan and/or Inova without restriction. For example, Inova may use aggregated data regarding claims paid for all participants in the Health Plan to help project benefit costs for the next year.

How Protected Health Information May Be Used and Disclosed
The Health Plan may use or disclose protected health information without your specific authorization for treatment, payment and healthcare operations. Each of these terms has the following meanings:

- "Treatment" means the provision, coordination or management of healthcare and related purposes. For example, the Health Plan may disclose protected health information to your doctor and his staff, third-party administrators and their staff, and other appropriate persons to help provide you with appropriate medical treatment.

- "Payment" means any actions undertaken by the Health Plan to obtain premiums, to determine responsibility for providing coverage, or to obtain or provide reimbursement for the healthcare services you receive. This includes, but is not limited to, eligibility and coverage determinations, billing, claims management and processing, plan reimbursement, reviews for medical necessity, utilization review, and pre-authorization for treatment. For example, the Health Plan may disclose to your doctor and his staff, third-party administrators and their staff and other appropriate persons, information concerning a particular medical procedure that you have had performed to determine whether the procedure is covered by the Health Plan.

- "Health care operations" means all the activities involved in the administration of the plan. This includes, but is not limited to, quality assessment and improvement, evaluating providers, underwriting and other duties relating to obtaining or amending insurance contracts, disease management, cost management, and other general administrative activities. For example, the Health Plan may use information about you to refer you to a disease management program, to evaluate the quality of care you are receiving from your providers, or to project benefit costs and determine premiums.

Protected health information may, in certain circumstances, be disclosed to Inova personnel who are involved in the administration of the Health Plan. These disclosures will be made in connection with Inova's role as the administrator of the Health Plan, and will be made to enable Inova personnel to carry out their duties in administering the Health Plan.

Such disclosures to and uses by Inova will be governed by written provisions of the Health Plan's plan documents. In many circumstances, it will be appropriate for Inova's administrative personnel to share protected health information with the Health Plan's business associates outside of Inova. Business associates assist the Health Plan with certain functions or activities, and include third-party administrators (such as Innovation Health Insurance Company and Aetna Life Insurance Company) lawyers, accountants, consultants and other appropriate persons.

In addition, the Health Plan may disclose protected health information to Inova (in its role as administrator of the Health Plan) or the Health Plan's business associates without your specific authorization so that Inova may obtain premium bids or for purposes of modifying or terminating the Health Plan. Information provided to Inova for these purposes will be in summary form. This means that the information will be limited to claims history, claims expenses, or types of claims experienced, with certain types of information removed. The Health Plan may also disclose plan enrollment and disenrollment information to Inova without your specific authorization.

Although the Health Plan may use and/or disclose protected health information for these administrative and healthcare operational purposes, the Health Plan cannot use or disclose health information that is genetic information for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits).

Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in you or your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services.

Other Uses and Disclosures of Protected Health Information
The Health Plan may use or disclose protected health information without your specific authorization for several other reasons, such as for public health purposes, auditing purposes, health oversight activities, certain judicial or administrative proceedings, emergencies, and when otherwise required by law. For example, the Health Plan may be required to disclose protected health information to law enforcement officials in specific circumstances or to the U.S. Department of Health & Human Services, which monitors compliance with the Privacy Rules.

The Health Plan may disclose protected health information without your written authorization to your family member, friend, or other person identified by you if the information directly relates to that person's involvement with your care or payment for your care, or if the disclosure is necessary to notify the family member or other individual of your condition or your location. In

such cases, you will be given an opportunity to agree or object to the disclosure, if you are able to do so.

The Privacy Rules permit other incidental uses and disclosures that occur as a by-product of a permissible or required use or disclosure. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by the Privacy Rules. The Health Plan has adopted reasonable safeguards to protect against uses and disclosures not permitted by the Privacy Rules and to limit incidental uses or disclosures.

However, those safeguards cannot guarantee the privacy of protected health information from any and all potential risks. In implementing safeguards, the Health Plan has considered the nature of the protected health information held, the potential risks to privacy, the potential effects on patient care, and the financial and administrative burden of particular safeguards. The Health Plan is not required to obtain your authorization or notify you if an incidental disclosure occurs.

Where use or disclosure is not otherwise permitted under the Privacy Rules, the Health Plan will ask for your written authorization before using or disclosing protected health information (and will obtain your authorization for any use or disclosure for marketing purposes, unless it is for healthcare operations). For instance, the Health Plan will ask for your written authorization before using or disclosing notes about you from your psychotherapist. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop future uses and disclosures, except to the extent the Health Plan has acted in reliance upon your authorization.

Individual Rights

In general, you have the right to review and receive copies of your protected health information maintained by the Health Plan in a designated record set (including obtaining electronically maintained information in an electronic format). This right is limited to enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; as well as records used to make decisions about individuals. You also may request that copies of your health information be sent to another entity or person, so long as that request is clear, specific and directs where the copies are to be sent.

If you request copies of this information, your request should be made in writing to the System Office Benefits Department at the address listed below, and the Health Plan will comply with the request within 30 days of your request, subject to a possible additional 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial. Any charge to you for these copies must be reasonable and based on Plan costs.

You have the right to request a list of certain disclosures of your protected health information in the six years preceding the date of your request.

However, the list will not include disclosures that were permitted to be made for treatment, payment or healthcare operations purposes or for national security, law enforcement or certain healthcare oversight activities. The Health Plan will provide you with one accounting a year for free, but may charge a reasonable cost-based fee if you ask for another accounting within 12 months of your most recent request.

In addition, if the Health Plan maintains electronic health records, you may (to the extent required by law) receive an accounting of disclosures made for treatment, payment, or

healthcare operations contained in such records, during the three years before the date of your request. For this purpose, an “electronic health record” is generally a record that contains health-related information for an individual which is gathered and consulted by authorized healthcare clinicians and staff.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the Health Plan correct existing information or add missing information. Your request should be made in writing to the System Office Benefits Department at the address listed below. The Health Plan has 60 days to respond to your request, subject to a possible additional 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial.

You may request in writing to the System Office Benefits Department that the Health Plan not use or disclose your protected health information for treatment, payment and healthcare operations except when specifically authorized by you, when required by law, or in emergency circumstances You may also request restrictions on disclosures to your family members or other individuals who are involved in your care or payment for your care. The Health Plan will consider your request, but is not legally required to accept it. If the Health Plan accepts your request, you will receive written notification from the System Office Benefits Department that your request has been accepted. If you pay the full cost of a healthcare item or service (without any payment from the Health Plan), you may request that a business associate (or healthcare provider) not disclose that item or service to another group health plan for payment or healthcare operations (but not for carrying out treatment) and your request must be honored.

The Health Plan will accommodate reasonable requests to receive communications of protected health information at alternate locations or by alternate methods, if the normal method of communication could endanger you. You may request a written copy of this Notice of Privacy Practices at any time by contacting the System Office Benefits Department at the address listed below, even if you previously agreed to receive this notice electronically.

Notice of Breach of Unsecured Protected Health Information
The Health Plan will notify you of any unauthorized access, use or disclosure (a “breach”) of your unsecured protected health information within 60 days of the Health Plan’s discovery of the breach. If the breach affects more than 500 individuals in a state or other jurisdiction, notice also will be provided through one or more prominent media outlets in the area. The notice will describe what happened (including the date of the breach and the date the breach was discovered), the type of protected health information involved, steps you should take to protect yourself, and steps the Health Plan will take to mitigate any harmful effects from the breach and to protect against future breaches.

The Health Plan’s Legal Duties
The Privacy Rules require the Health Plan to maintain the privacy of protected health information and to provide this Notice of Privacy Practices. The Health Plan may change Its privacy policies at any time, and changes may apply to all protected health information held by the Health Plan at the time of the change.

When the Health Plan makes a significant change in its policies, a revised Notice of Privacy Practices will be distributed to all current Health Plan participants within 60 days of the change.

This notice and Inova’s privacy policies do not create any legal rights, contractual or otherwise, under state or federal law, but simply give you notice of the Plan’s obligations under the Privacy Rules and your rights under the Privacy Rules.

Complaints
If you are concerned that Inova or the Health Plan has violated your privacy rights, or you disagree with a decision made about access to or amendment of your health records, you may contact the Health Plan's Privacy Officer at the address listed below. You may also send a complaint by sending a letter to the Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F HHH Bldg., Washington, DC 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/hipaa/filing-a-complaint/**. Neither the Health Plan nor Inova may retaliate against you in any way for exercising your right to file a complaint.

You may contact the System Office Benefits Department at the following address and phone number for more information on the Health Plan's privacy practices:

Inova
Inova Benefits Department
8095 Innovation Park Dr
Fairfax, VA 22031
1-703-205-2166