Inova Health System
Health & Welfare Benefits Plan

Summary Plan Description

As Updated January 1, 2020

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INOVA HEALTH SYSTEM
HEALTH AND WELFARE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

Introduction

Inova Health System (the "Company") has established the Inova Health System Health and Welfare Benefits Plan (the "Plan") to consolidate in one plan document certain provisions of health and welfare benefit plans (the "Component Benefit Programs") sponsored by the Company and its affiliated employers, and to provide uniform administration of such health and welfare benefits. The Component Benefit Programs are listed in Exhibit A to this Summary Plan Description. This Summary Plan Description ("SPD") is effective January 1, 2020.

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 and Welfare Benefits Plan. The Plan sponsor is Inova Health System Foundation. The Company's address is Inova Health System, Attn: Human Resources, 8110 Gatehouse Road, 2nd Floor, Falls Church, VA 22042. 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 506.

Type of Health and Welfare Benefits Plan. The Plan provides various health and welfare benefits 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

Your eligibility for benefits under each of the Component Benefit Programs depends on how many hours you are budgeted to work.

- Full-time (60 hours or more per pay period): You are eligible for all benefits.
- Part-time (40–58 hours per pay period): You are eligible for all benefits except Long-Term Disability (LTD).
- Fewer than 40 hours per pay period: You generally are only eligible for the Employee Assistance Program, Inova HealthNET Programs, the 401(k) plan, and certain voluntary benefits (via direct debit deduction). If you work an average of 30 hours or more per week during a 12-month "lookback period," you will become eligible for medical benefits during the subsequent plan year.

The following dependents are also eligible:

- Your legal spouse, domestic partner of either sex (based on requirements for domestic partnership established by the Plan Administrator) or common law spouse.
- Your child(ren) under age 26, or any age if disabled. 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.

If you and your spouse or child work for Inova, your spouse or child cannot be covered as both a Team Member and a dependent. Also, you and your spouse cannot both claim your children as your dependents.

In order to add a dependent to your coverage, you will need to provide certain required documentation of eligibility within 45 days (60 days for newborns/adoptions) of submitting your dependent(s) for coverage. If documentation is not timely received, or if you submit insufficient documents, your unverified dependents will be dropped from coverage

retroactively to the original enrollment date; and, you will be responsible for claims processed during this time.

Descriptions for the benefits provided under each Component Benefit Program are available at www.inova.org/benefits.

Participation in the Plan will generally terminate on the later of your last day of employment or the last day of participation in any Component Benefit Program. You may become ineligible for any benefit under the Plan if you fail to pay the applicable premiums or meet other requirements of a particular Component Benefit Program.

Cafeteria Plan Rules

The Plan includes a "Cafeteria Plan" component that permits you to elect to use a portion of your compensation to pay for the cost of coverage under certain Component Benefit Programs on a pre-tax basis.

Benefit Elections

The Plan operates on a 12-month Plan year that begins on January 1 and ends on December 31. The elections for benefits are made on a Plan-year basis. Once you have made your elections for a Plan year, they pertain to the entire Plan year and cannot be changed or canceled during that time except in certain limited situations, which are described in this SPD.

If you first become eligible to participate in the Plan during a Plan year in progress, your initial elections pertain to the remaining part of that Plan year. Then, before each new Plan year begins, you will have an opportunity to change or cancel your elections during the annual election period. The annual election period is described below.

Making Your Elections

In making your elections, you may:

- elect and enroll for some or all of the benefits available under the premium conversion component of the Plan;
- elect to contribute to a Healthcare Flexible Spending Account ("FSA") and/or a Dependent Care FSA;
- elect to contribute to a Health Savings Account ("HSA"), if you are otherwise eligible to do so.

You may also elect not to enroll or make contributions if you do not wish to do so. If you are a new full-time Team Member or if your work status changes to full-time and fail to make any elections (generally within 31 days of becoming eligible for benefits), you will be deemed to have elected employee-only coverage in the High Deductible medical plan, which allows you to open a Health Savings Account. If you are a new part-time Team Member eligible for benefits and you fail to make any elections, you will have no coverage.

When you make your elections, you also authorize the necessary salary reductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a Plan year, you will be given an opportunity to elect and enroll for the benefits for which you are newly eligible. If you have elected benefits under a Component Benefit Program other than a FSA and the cost of the benefits changes during the Plan year, the amount of your salary reduction contributions will be automatically adjusted.

Annual Election Period

Before the beginning of each Plan year, the Company will hold an annual election period. The Company will notify you when the dates for the annual election period will occur each year. During this time, you may make new elections for the upcoming Plan year. If you do not make any changes during the annual election period, and unless noted otherwise, you will be deemed to have:

- made the same election for the upcoming Plan year as you made for the previous Plan year for the Component Benefit Programs (except for any FSA elections you had in place for the prior year);
- authorized salary reduction contributions for the upcoming Plan year equal to your share of the cost of each benefit deemed to have been elected.

If you do not affirmatively elect FSA benefits during the annual election period, you will not be enrolled in these benefits during the next plan year (regardless of what your FSA election was for the preceding year).

Changing Your Elections During a Plan Year

You generally may not change or revoke your benefit elections during the Plan year except if you experience a qualifying event, also known as a life status change. However, as a result of the COVID pandemic, during 2020 you may make certain mid-year changes on a prospective basis regardless of the reason for your request. Refer to ***Exceptions for Making or Changing your Plan Year 2020 Elections*** at the end of this section for details.

Except as otherwise specifically described in that section, you may only make a mid-year change in accordance with the following rules:

Due to HIPAA Special Enrollment Rights

If you become covered, or your spouse or dependent child becomes covered, under our group health plan or Healthcare FSA during a "Special Enrollment Period" required by the Health Insurance Portability and Accountability Act ("HIPAA"), you may prospectively make a corresponding change in your Cafeteria Plan election so that you may pay your contributions for the group health plan or Healthcare Flexible Spending Account benefits on a pre-tax basis.

Under HIPAA, Special Enrollment Periods are generally allowed due to certain losses of other group health coverage and changes in family status. A Special Enrollment Period is allowed due to a loss of other group health coverage if you:

- declined coverage under our group health plan for yourself or your dependents when you first became eligible for it because you had other group (or "COBRA") coverage;
- lose the other group coverage (or if the employer stops contributing towards your or your dependents' other coverage); and

- request enrollment in our group health plan within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards your or your dependents' other coverage).

A Special Enrollment Period is allowed due to a change in family status if you are eligible for coverage under our group health plan and you gain a dependent through marriage, birth, adoption, or placement for adoption.

Due to Eligible Status Changes

If you experience an Eligible Status Change, you may prospectively revoke or change your previous benefits elections in a manner that is consistent with the Eligible Status Change. Eligible Status Changes are changes in a person's eligibility status due to at least one of the following events:

- a change in your legal marital status through marriage, the death of your spouse, divorce, legal separation (as determined under state law), or annulment.
- a change in the number of your dependents for federal income tax purposes through birth, adoption, placement for adoption, or the death of a dependent.
- the beginning or termination of your employment or your spouse or dependent's employment.
- a reduction or increase in your working hours, those of your spouse or dependent, including work-hour changes resulting from a switch between part-time and full-time employment, strike, lockout, or the beginning or end of an unpaid leave of absence.
- your dependent satisfying or ceasing to satisfy the requirements for eligibility (for example, by attaining the age limit).
- a change in your workplace or residence or that of your spouse or dependent.

An election change is "consistent with" an Eligible Status Change only if it is related to and corresponds with the particular Eligible Status Change that has occurred. For example, you may not cancel coverage for your spouse who has become eligible for coverage under another plan due to an Eligible Status Change unless he or she actually becomes covered under the other plan. However, if you are permitted to add coverage under our group health plan for a spouse or dependent child due to an Eligible Status Change, you may also, at the same time, add group health plan benefits for your other eligible family members.

Due to Entitlement to COBRA

You may change your health benefits election if you become, or your spouse or dependent child becomes, entitled to continued coverage under our group health plan under the federal law known as "COBRA" or because of a state-mandated continuation of group health plan coverage.

Due to a Qualified Medical Child Support Order

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. If you are required to provide health coverage to your child(ren) by a QMCSO issued due to a divorce, legal separation,

annulment or change in legal custody, you may change your benefits elections with respect to our group health plan benefits.

Due to Changes in Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Entitlement

If you become entitled to or cease to be entitled to Medicare, Medicaid, or a State's children's health insurance program (SCHIP), or if your spouse or dependent child does so, you may make a corresponding change to your health benefit elections. In the case of a loss of Medicare or SCHIP coverage, you may elect Plan health benefits for up to 60 days following the date that coverage is lost. Also, if you or your dependents become eligible to receive healthcare premium assistance under a Medicaid or SCHIP program, you may elect health benefits under the Plan within 60 days of the date you or your dependents become eligible for the assistance.

Due to Eligible Changes in Coverage under the Plan

If coverage under any benefit provided through the Plan is significantly curtailed or terminated during the Plan year and you are affected by the change, you may make an election change to elect another option providing similar coverage. Coverage under group health plan benefits is "significantly curtailed" only if there is an overall reduction in coverage that affects all covered participants. If benefits are significantly curtailed and no alternative option is available under the Plan, revocation of the election is permitted.

If benefits are added to or eliminated from the Plan during the Plan year and you are affected, you may make an election change to elect the new benefits or replace the eliminated benefits with another benefit (other than Healthcare Flexible Spending Account benefits) providing similar coverage, if one is available under the Plan.

Due to Eligible Changes in Coverage under a Family Member's Plan

In certain situations, you may make a prospective election change due to and consistent with a change in coverage under a Cafeteria Plan sponsored by the employer of your spouse, former spouse, or dependent. You can do so when the change in coverage results from either: (i) an election change permitted under that plan due to an Eligible Status Change or an eligible change in coverage; or (2) an election change made during that plan's annual election period, if its plan year does not coincide with the Plan year of our Cafeteria Plan.

Due to Changes in Coverage Costs

If the cost that is charged to all participants for a benefit is significantly increased during the Plan year and you are affected, you may prospectively change your election to elect another benefit option providing similar coverage, if one is available under the Plan. If no such alternative option is available, revocation of the election is permitted.

Due to Changes in Dependent Care Providers or Hours of Care Provided

You may change your Dependent Care Flexible Spending Account election due to a change in your dependent care provider. You may also change your election if there is a reduction in the number of hours of dependent care services provided.

Due to Changes in Dependent Care Expenses

You may change your Dependent Care Flexible Spending Account election due to a cost change imposed by your dependent care provider, unless that provider is your relative.

A mid-year election change due to any of the above events must be made within your election window, which is generally 31 days after the occurrence of the event. It will generally take effect on the event date or the 1st of the month following the date you submit your election change. However, if you are enrolling a dependent child pursuant to the HIPAA Special Enrollment Rights and you notify the company within 60 days of the dependent's birth or adoption, your election change will apply retroactive to the date of birth or adoption.

NOTE that from March 1, 2020 until 60 days after the end of the declared COVID-19 national emergency (or another date specified by the government), the time periods for making election changes due to HIPAA Special Enrollment Rights will be extended. For more information on the extensions, visit www.inova.org/benefits or contact the Plan Administrator.

No changes may be made to your Healthcare FSA benefit elections during a Plan year except for changes due to HIPAA Special Enrollment Rights or Eligible Status Change.

Exceptions for Making or Changing your Plan Year 2020 Elections

In response to the COVID-19 pandemic and related IRS guidance, the Plan is being amended to allow you to make certain prospective mid-year changes to your 2020 Healthcare FSA benefits. During the period from May 1, 2020 through December 4, 2020, you may revoke an election, make a new election, or decrease or increase an existing election to a Healthcare FSA. However, if you decide to revoke or decrease your election, you may not reduce your FSA contributions to a level that is lower than any amounts you have already been reimbursed as of that date.

Note that even if you change your election in 2020, in order to make FSA contributions in 2021 you must make a new election during the Annual Enrollment period for 2021.

Contributions for Your Benefits

Your contributions toward the costs of benefits are paid by salary reduction. Your compensation will be reduced by the total amount of your contributions for the benefits you elect. Your pay in each pay period will be reduced by a proportionate amount of the total annual contribution. The reduction in your pay will be adjusted automatically in the event of a change in your cost for the benefits you have elected during the Plan year.

Benefits provided to you will end if you fail to make the required contributions for the benefits. If benefits end for this reason, you may not resume premium payments and make new benefit elections within the Plan during the remaining portion of the Plan year.

The Company may make periodic contributions toward the cost of some or all of the benefits provided under the Plan. We reserve the right to increase, decrease, or eliminate our contribution for any benefit available under the Plan at any time.

Flexible Spending Account Benefits

A Flexible Spending Account ("FSA") can help you pay for eligible expenses with pre-tax dollars, reducing your taxable compensation for the year. The Healthcare FSAs are designed to reimburse you for qualified out-of-pocket medical, dental and vision expenses, including deductibles, coinsurance and copayments that are not covered by your healthcare coverage with the Company or another source. The Dependent Care FSA can help you pay for the

care of an eligible dependent so you and your spouse can work, look for work or attend school as a full-time student.

Types of FSAs

The Company offers three types of flexible spending accounts. If you are eligible, you may only enroll in one of the two healthcare FSA options. It is important that you understand the advantages and limitations before you decide whether to participate.

Flexible Spending Account	Examples of Common Eligible Expenses	Additional Information
Healthcare FSA	Medical, dental and vision • Deductible • Copays and coinsurance • Other healthcare expenses	• You cannot be enrolled in a Health Savings Account. • You do not need to be enrolled in a Company health plan.
Limited Healthcare FSA	Dental and vision • Dental expenses • Eyeglasses • Contact lenses	You must be enrolled in one of the Company's High Deductible Plans.
Dependent Care FSA	Dependent care • Child care • Before- and after-school programs; au pair • Elder care	• Eligible dependents include dependent child(ren) up to age 13 who live with you; or, disabled dependent(s) you claim on your tax return who live with you or spend at least eight hours a day in your home.

Enrollment and Elections

If you are eligible to participate, you will be provided an opportunity to enroll in each of the applicable FSAs within 31 days after your date of hire or eligibility. The amount of your contribution will be taken on a substantially pro-rata basis each payroll period, in accordance with your election.

For the Healthcare FSA and Limited Healthcare FSA, the maximum contribution you can make for the year is $2,750 (for 2020). This amount may be increased by the Plan Administrator from time to time to reflect increases in the limit due to cost-of-living changes. For the Dependent Care FSA, you may contribute up to $5,000, if you are married filing a joint return or you are head of household, or $2,500 if your filing status is married filing separately. (Note that for spouses who file jointly, the total limit is $5,000 for both spouses.) However, lower limits may apply to participants who are considered "highly compensated." You will be informed if a lower limit applies to you.

During each Annual Enrollment period, you must re-enroll to participate in the FSAs for the upcoming year. Your participation will end as of the end of the calendar year if you do not elect to participate during the Annual Enrollment period for the following year.

If you enroll during the Annual Enrollment period, your participation begins the following January 1. If you enroll within your first 31 days of eligibility, your participation begins on the first day of the month coincident with or following your date of hire. If you enroll at any other time of the year because of a qualifying event, your participation begins on the effective date of the change.

Generally, your election is irrevocable for the calendar year, unless you experience certain qualifying life events. Refer to **Changing Your Elections During a Plan Year** for more information.

Your contributions for each FSA are allocated separately and cannot be combined; and, you cannot transfer the amount designated during your enrollment for either Healthcare FSA to the Dependent Care FSA, or vice versa, for any reason during the year.

Healthcare FSAs

You can use the Healthcare FSAs to reimburse your and your eligible dependents' health-related charges. This includes your spouse, children up to age 26, and any of your dependents eligible under the Plan, even if your dependents are not covered under the medical plan offered by the Company. However, note that you may only submit expenses for your domestic partner if your domestic partner qualifies as your dependent.

Reimbursement from the Healthcare FSA or Limited Healthcare FSA is available only after the service for which you are seeking reimbursement is performed and you receive reimbursement from all other sources. You can pay for eligible healthcare expenses by using your debit card (as described further below) or by seeking reimbursement for expenses you paid directly.

Reimbursable and Non-Reimbursable Expenses

The Healthcare FSA reimburses you for many, but not all, healthcare expenses that are tax deductible. In general, you can receive reimbursement for expenses incurred for medical care, which includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, provided that they are not reimbursable from any other source and, if they are eligible for a tax deduction under IRS guidelines, you do not take the tax deduction. An expense is "incurred" when the service or treatment related to the expense is provided—not when the expense is paid; however, orthodontia services are deemed to be incurred when the you make the advance payment. Expenses incurred to merely benefit your general health or for personal reasons (such as cosmetic surgery, other than to correct or cure a deformity or correct a congenital abnormality) are not considered expenses for medical care. Refer to IRS Publication 502 or go online to www.payflex.com for a listing of eligible reimbursable expenses. Note that effective January 1, 2020, you may use your Healthcare FSA funds to purchase certain over-the-counter medications, without a prescription, and feminine care products.

The Limited Healthcare FSA covers only dental and vision expenses.

Healthcare FSA Reimbursement Process

You may pay your qualified healthcare expenses directly with your FSA debit card issued to you by the FSA claims administrator. Alternatively, you can file a claim for reimbursement by completing the claim submission process with your claims administrator. When you submit a claim, you must also provide supporting documentation, including the dates of service, the provider's name, the name of the eligible person receiving the services (you or your eligible dependent), the services that were received, and the incurred cost. Claim forms are available online at www.inova.org/benefits.

If you use the debit card, you do not have to submit a claim for reimbursement. You should retain your receipts because you may be required to substantiate your expenses.

Substantiation is the process of providing the detailed receipt/claim to support that the charges to the debit card are FSA eligible.

If you are requesting reimbursement using a claim form, submit the appropriate supporting documentation, such as:

- The explanation of benefits (EOB) from the insurance company;
- An itemized bill for services not covered by insurance, including the name of the service provider, cost of the service, patient name, description of the services rendered and date of service;
- Receipts for any medications and copays; and
- Copies of any prescriptions if the receipt for the medication does not include an Rx number.

Debit Card

If you elect to contribute to a Healthcare FSA, you will receive a package containing one debit card issued in your name, activation instructions, a cardholder agreement, additional disclosures, and information explaining approved use of the card.

By signing and using the card, you certify that:

- You will only use the card for your own eligible healthcare expenses and those of your eligible dependents under the Healthcare FSA.
- Incurred expenses were for healthcare services or supplies purchased on or after the date your Healthcare FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

You may use your debit card for eligible healthcare expenses at merchants and providers that accept Mastercard and health care cards – such as doctor and dental offices, pharmacies, and some discount and grocery stores. Refer to www.payflex.com for more information on how the debit cards work.

Dependent Care FSA Participants will not receive a debit card. If you enroll in both a healthcare FSA and the Dependent Care FSA, you can only use the debit card for the Healthcare FSA. If you are enrolled in both an HSA and a Limited Healthcare FSA, you will receive one debit card for both.

Important: Save your itemized receipts!

Because all debit card transactions must be verified as eligible healthcare expenses, you may be required to substantiate your purchase. For this reason, make sure that you save all of your itemized receipts (indicating the date of service, the name of the service provider, the name of the person receiving service, the name of the product or service, and any amount paid by other coverage). If PayFlex needs more information to confirm a debit card purchase, they will notify you. If you don't respond to a documentation request, your card may be suspended until you either send in the requested documentation or pay back the account. In addition, the processed charges that require substantiation will be considered an overpayment. Refer to the next section for the Overpayment Process.

Overpayment Process — Healthcare FSA and debit card use

An overpayment is any payment made to you (for the benefit of you and/or your dependent) in excess of the amount properly payable under the Plan.

Overpayments under the Healthcare FSA or Limited Healthcare FSA can occur when:

- You have been reimbursed for a healthcare expense that has been denied because you did not submit supporting documentation to substantiate your claim;
- You used your FSA debit card when a provider requires you to pay before insurance pays (e.g., if your dentist charges you for an estimated amount or an amount that is greater than the amount you owe); or
- You used your FSA debit card for an ineligible expense.

Your Explanation of Payment (EOP) from the FSA claims administrator will tell you what claims have been approved for reimbursement, denied, or whether your account is in overpayment status.

If you have an overpayment, the FSA claims administrator may temporarily suspend your debit card until you submit the required documentation or payment. You may continue to request reimbursement by submitting a paper claim. If you do not repay your account, the amount due may be deducted from your pay (to the extent permitted under applicable law) or the FSA claims administrator may deduct the overpayment amount from future valid claims until the amount due is recovered.

If the recovery methods described above are not adequate to recover all of the improper payment(s), the unsubstantiated charges may be considered taxable income and reported on your Form W-2.

To keep your card active and avoid overpayment, you may want to limit use of your debit card to fixed dollar copays or to pay a provider after a visit, once insurance has processed the claim and provided you with an Explanation of Benefits (EOB) showing the amount you owe.

Deadline for Filing Claims for the Plan Year

All claims under the FSAs must be received by the FSA administrator by March 31 following the year for which the FSA applies.

NOTE that from March 1, 2020 until 60 days after the end of the declared COVID-19 national emergency (or another date specified by the government), the time periods for submitting Healthcare FSA and Limited Healthcare FSA claims will be extended. For more information on the extensions, visit www.inova.org/benefits or contact the Plan Administrator.

Uniform Coverage Rule

You are entitled to reimbursement from your Healthcare FSA or Limited Healthcare FSA for eligible expenses, while coverage is active, for the full amount of your annual election as of your first day of coverage. This is called the “uniform coverage rule”. You will continue to be reimbursed for eligible expenses, incurred while coverage is active, until your total reimbursements equal the annual amount you elected to contribute to your Healthcare FSA or Limited Healthcare FSA.

This rule does not apply to the Dependent Care FSA, and reimbursements from the Dependent Care FSA can’t exceed the amount that you have contributed to date.

Forfeiture of Unused Balances

In accordance with Internal Revenue Service rules governing FSAs, any unused balances in your FSAs at the end of the applicable Plan Year will be treated as follows:

- Any remaining Healthcare FSA balance up to $550 (or a larger amount permitted by the IRS for years after 2020) will carry over to the next Plan year. Any amounts above this limit will be forfeited.
- For Plan years 2019 and earlier, any remaining unused Dependent Care FSA funds as of December 31 of the Plan year will be forfeited. Beginning with the 2020 Plan year, Dependent Care FSA funds remaining at the end of a Plan year may be used to reimburse eligible expenses incurred until March 15th of the following year (the "grace period"). To be eligible for the grace period, you must be a participant in the plan on December 31; however, you are eligible for coverage during the entire grace period even if your employment terminates during the grace period or you do not elect to contribute to the Dependent Care FSA during the new Plan year. Amounts remaining at the end of the grace period will be forfeited.

Example:

Assume	**Healthcare FSA**	**Dependent Care FSA**
2020 contributions to FSA	$1,500	$3,000
2020 qualified expenses incurred	$ 800	$2,500
FSA balance on December 31, 2020	$ 700	$ 500
Carryover to 2021	$ 550	Not applicable
Available for use during grace period* (January 1 – March 15, 2021)	Not applicable	$ 500
Amount remaining as of March 15, 2021	Not applicable	$ 300
Amount of 2020 FSA contributions forfeited	$ 150	$ 300

** effective with the 2020 Plan year (grace period in 2021)*

This 'use-it-or-lose-it' rule means it is very important that you estimate your eligible expenses carefully in deciding the FSA benefit amount you will elect for each Plan year.

Contributions During an FMLA Leave of Absence

If you have elected and are covered under group health plan benefits (including Healthcare FSA or Limited Healthcare FSA benefits) through the Cafeteria Plan, you are permitted to maintain your coverage during qualified leaves of absence under the Family and Medical Leave Act ("FMLA"). If you choose to do so, you are responsible for paying the portion of the cost of the group health plan benefits that had been contributed via salary reduction contributions while you were working. We will explain the available methods for paying your contributions for coverage during a qualified FMLA leave of absence. Your contributions, if any, will continue during the qualified leave of absence.

Highly Compensated and Key Employees

Under the Internal Revenue Code, the amount of contributions to and benefits under FSAs may be limited for participants who are classified as "highly compensated" or "key

employees." The Company will notify you if you are affected by these limitations and will adjust your contribution elections accordingly.

Termination of Employment

If your employment terminates during a Plan Year, you generally may only receive reimbursements from your Healthcare FSA, Limited Healthcare FSA, or Dependent Care FSA for expenses incurred prior to your termination of employment (unless your employment terminates during the grace period for the Dependent Care FSA, as described above). However, you may have the opportunity to contribute to your Healthcare FSA or Limited Healthcare FSA with after-tax dollars and continue to use the funds for expenses incurred after termination of employment if you qualify for continuation coverage under COBRA. See Exhibit B for more details on your COBRA continuation rights. You generally will be eligible for COBRA continuation coverage only if there is a positive balance in your Healthcare FSA or Limited Healthcare FSA (including any amounts carried over as described above) at the time of the COBRA "qualifying event," taking into account all claims submitted before the date of the qualifying event.

You will not be eligible for COBRA continuation coverage with respect to the Dependent Care FSA.

Circumstances that May Reduce Your Benefits

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

- You do not qualify as an eligible employee.
- Your requests for reimbursement exceed the amount you contributed to your FSA.
- You fail to file a claim for reimbursement within the specified time limits.
- You fail to properly substantiate a reimbursement request.
- A portion of your FSA balance is forfeited because your contributions to the FSA for the Plan Year exceed your health care expenses for the Plan Year.
- Your reimbursements are stopped or decreased because a prior reimbursement was determined not to satisfy the IRS rules for health care expenses.

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 address of (and other contact information for) the individual insurance company and/or third party administrator that reviews claims made under a Component Benefit Program is set forth on Exhibit A. All other general claims or requests should be directed to the Plan Administrator.

NOTE that beginning March 1, 2020 until 60 days after the end of the declared COVID-19 national emergency (or another date specified by the government), the time periods above for submitting claims will be extended. For more information on the extensions, visit www.inova.org/benefits or contact the Plan Administrator.

General Claims Procedure

The following procedures will be followed for denied claims under a Component Benefit Program that is not a group health plan or long-term disability plan.

Notification of Denial

If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. This 90-day period may be extended an additional 90 days under special circumstances. The notification will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Program on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure.

Appeal of Denied Claim

Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator at the Company's address. Documents or records in support of your appeal should accompany any such request. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator has the exclusive and discretionary right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding. However, if you decide to file a civil suit for denied benefits, the suit must be filed within one year of the date of the benefit denial on appeal.

Special Rules for Group Health Plan Claims and Disability 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 Group Health Claim or Disability 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 healthcare claims under the Plan depends on the urgency of the claim. The deadlines shown on the chart below are maximum time limits for healthcare and disability claims.

Time Limit	Urgent Care Health Claim	Pre-Service Health Claim	Post-Service Health Claim	Disability Claim
To make initial claim determination	72 hours	15 days	30 days	45 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days	30 days (twice)
To request missing information from claimant	24 hours	5 days	30 days	
For claimant to provide missing information	48 hours	45 days	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*	*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	45 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	*Not applicable*		45 days	

Notification of a Group Health Claim or Disability Claim 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:

Group Health Claims	Disability Claims
The date of service, the healthcare provider, the claim amount (if applicable) and the denial code and its corresponding meaning, as well as a statement that the claimant may request the applicable diagnosis and treatment codes (and their meanings)	*Not applicable*

<table>
<tr><th>Group Health Claims</th><th>Disability Claims</th></tr>
<tr><td colspan="2">The specific reason or reasons for the denial</td></tr>
<tr><td colspan="2">Reference to the specific Plan provisions on which the denial was based</td></tr>
<tr><td colspan="2">A description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary</td></tr>
<tr><td>If the claim is for Urgent Care, a description of the expedited review process applicable to such claims</td><td>Not applicable</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td>The specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>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.”</td><td>Not applicable</td></tr>
<tr><td>The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures</td><td>Not applicable</td></tr>
<tr><td colspan="2">Any other information required by law</td></tr>
</table>

Disability Claims. If a claim for disability benefits is denied, in addition to the information listed above, the notice of denial will also contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the opinions of healthcare professionals treating the claimant and vocational professionals who evaluated the claimant, provided to the Plan by the claimant;
- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's benefit denial, without regard to whether the advice was relied upon in making the denial; and
- a disability determination regarding the claimant made by the Social Security Administration, provided to the Plan by the claimant.

The notice will also include 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.

How to Appeal a Denied Group Health Claim or Disability Claim

If your healthcare claim or disability 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 Appendix 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 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.

Group Health Claims. 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.

Disability Claims. Before issuing a denial on review of a disability benefit claim, the claims administrator must also provide the claimant, free of charge, with the following information:

- Any new or additional evidence considered, relied upon, or generated by the plan, claims administrator, or other person making the benefit determination in connection with the claim. Such evidence must be provided as soon as possible, giving the claimant a reasonable opportunity to respond before the reviewer's deadline for making a decision on review; and
- Any new or additional rationale used to issue an adverse benefit determination. The rationale must be provided as soon as possible, giving the claimant a reasonable opportunity to respond before the reviewer's deadline for making a decision on review.

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:

<table>
<tr><th>Group Health Claims</th><th>Disability Claims</th></tr>
<tr><td>The date of service, the healthcare provider, the claim amount (if applicable) and the denial code and its corresponding meaning, as well as a statement that the claimant may request the applicable diagnosis and treatment codes (and their meanings)</td><td>Not applicable</td></tr>
<tr><td colspan="2">The specific reason or reasons for the denial</td></tr>
<tr><td colspan="2">Reference to the specific Plan provisions on which the denial was based</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>A statement of your right to bring a civil action in court</td><td>A statement of your right to bring a civil action in court, including a description of any limitations period that applies to the right to bring an action, and the calendar date on which the limitations period expires</td></tr>
<tr><td>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</td><td>The specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.</td></tr>
<tr><td>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</td><td>Not applicable</td></tr>
</table>

Group Health Claims	Disability Claims
The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures	*Not applicable*
Any other information required by law	

External Review Procedures for Group Health Claims

If you have exhausted the internal appeals process described above, you may be entitled to an independent, external review of a group health claim that is denied upon appeal if the claim relates to:

- Retroactive cancellation of group health insurance coverage; or
- An adverse determination based on a medical judgment.

A request for external review must be filed in writing with the Plan Administrator within four (4) months following receipt of an adverse determination.

You may request an expedited external review under the following conditions:

- At the time of an initial adverse benefit determination (or following denial on appeal) if the denial relates to a medical condition for which the timing of the normal appeal process would endanger the life or health of the claimant or could jeopardize the claimant's ability to regain maximum function; or
- At the time of an adverse benefit determination on appeal if the denial relates to an inpatient admission, availability of care, continued stay, or healthcare item or service for which the claimant received emergency services but has not been discharged from a facility.

Timetable for External Review of Group Health Plan Claims

Task	External Review	Expedited Review
Determine whether claim qualifies for external review (preliminary review)	5 business days	Immediately upon receipt
Provide notice to claimant regarding preliminary review	Within 1 business day of completing preliminary review	Immediately upon completing preliminary review
For claimant to provide missing information	By later of: 4 months following receipt of adverse determination upon appeal OR 48 hours following request for missing information	

If the claim is not eligible for external review, the Plan Administrator will issue a notice that gives the reasons the claim is not eligible as well as contact information for the Employee Benefits Security Administration. If the claim for external is not complete, the Plan Administrator will issue a notice that describes the information that is needed.

If the claim is eligible for external review, the Plan Administrator will refer the appeal to an independent review organization, in accordance with federal regulations. The independent review organization will conduct the review and provide appropriate notices as required by federal regulations. If the independent review organization reverses the plan's decision, the Plan will provide coverage or payment for the claimed services, but reserves the right to seek judicial review of the independent review organization's decision.

For more information about the external review process, contact your group health plan provider as described in Exhibit A.

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

Family Medical Leave Act Coverage

A Participant who is on an authorized leave of absence under the Family Medical Leave Act of 1993 (FMLA), may continue participation in the Plan for up to 12 weeks. Such participation will be provided under the terms and conditions of the applicable Component Benefit Program, including the rate of contributions that would have been applicable if the Participant had continued employment and subject to the terms and conditions of the FMLA policy of the employer.

Uniformed Services Employment and Reemployment Rights Act Coverage

Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

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 and dental plans 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. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly. 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.

No Guarantee of Employment

Nothing contained in the Plan shall be construed as a contract of employment between an Employer and an Employee or Participant, or as a right of any Employee or Participant to continue in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of the Participants, with or without cause.

Effect of Divorce on Beneficiary Designation

If you have designated your former spouse or domestic partner as beneficiary under one or more of the Component Benefit Program(s), such designation will be null and void as of the date of your divorce or termination of domestic partnership unless a divorce decree or corresponding property settlement agreement expressly provides otherwise.

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.

No Assignment of Benefits

You may not assign or delegate to a third party (like a healthcare provider) any right or benefit you may have under this Plan, without the consent of the Plan Administrator or claims administrator. Although the Plan Administrator or claims administrator may pay a third party provider directly for services provided to you or your dependent, that is not considered an "assignment of benefits."

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 employee 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 group 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, 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;
- 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); and
- You fail to cash a check for an uninsured benefit within six months of the date on the check. Checks not cashed within six months will be stopped; the benefit will be forfeited and the check will not be reissued.

Coordination of Benefits

If you and/or your dependents are covered under another group 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 covered under this Plan is also covered under another parent's or step-parent's plan, and the above rules do not establish 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.

If you or your spouse are enrolled in Medicare or are eligible for Medicare, the following coordination of benefit rules apply to you:

- This Plan pays before Medicare if you are still an employee (even if you are receiving short-term disability benefits or otherwise out on paid disability leave for up to 6 months); and
- This Plan pays before Medicare for the first 30 months of Medicare coverage if you are entitled to Medicare because you have end-stage kidney disease.

This Plan will pay secondary to Medicare in all other circumstances (even if you haven't yet enrolled in Medicare). This means that benefits paid by this Plan will be reduced by the amount Medicare would have paid if you had been enrolled.

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 & Welfare Benefits Plan (the "Plan"), you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 healthcare 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 welfare benefit or exercising your rights under ERISA. 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.

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 - Contact Information For Filing Claims For Benefits

As of January 1, 2020

Carrier and address	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
Basic Hospital Indemnity (Insured) Aetna Voluntary Plans P.O. Box 14079 Lexington, KY 40512-4079	1-888-772-9682	www.myaetnasupplemental.com
Accident (Insured) Aetna Voluntary Plans P.O. Box 14079 Lexington, KY 40512-4079	1-888-772-9682	www.myaetnasupplemental.com
Critical Illness (Insured) Aetna Voluntary Plans P.O. Box 14079 Lexington, KY 40512-4079	1-888-772-9682	www.myaetnasupplemental.com
Dental – Aetna High (Self-Insured) Aetna, Inc. P.O. Box 14094 Lexington, KY 40512-4094	1-800-862-5441	www.aetna.com
Dental DMO (Insured) Aetna, Inc. P.O. Box 14094 Lexington, KY 40512-4094	1-877-238-6200	www.aetna.com
Vision (Insured) VSP P.O. Box 997105 Sacramento, CA 95899-7105	1-800-877-7195	www.inova.vspforme.com

Carrier and address	Phone number	website
Flexible Spending Accounts PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000	1-888-678-8242	www.payflex.com
Health Savings Account PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000	1-888-678-8242	www.payflex.com
Short-Term Disability (Self-Insured) Cigna P.O. Box 22328 Pittsburgh, PA 15222-0328	1-888-84-CIGNA	www.mycigna.com
Long-Term Disability (Insured) Cigna P.O. Box 22328 Pittsburgh, PA 15222-0328	1-888-84-CIGNA	www.mycigna.com
Life Insurance and AD&D (Insured) Cigna P.O. Box 22328 Pittsburgh, PA 15222-0328	EOI status: 1-866-607-2360 AD&D conversion: 1-800-423-1282 Life Conversion/Port: 1-800-441-1832	www.mycigna.com
Legal Plan (Insured) Hyatt Legal Plans, part of Metropolitan Life Insurance Co.	1-800-821-6400	www.legalplans.com

Exhibit B - General Notice Of Cobra Continuation Coverage Rights

Introduction

You are receiving this notice because you are covered under a group health plan or health flexible spending account plan under the Inova Health System Health & Welfare Benefits Plan sponsored by Inova Health System (collectively, the "Plan"). This notice contains important information about your right 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 you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you 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 you when you would otherwise lose your group health coverage. It can also 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.

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

NOTE that beginning March 1, 2020 until 60 days after the end of the declared COVID-19 national emergency (or another date specified by the government), 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. 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." You, 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 an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an 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's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- 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-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-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."

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 end of employment or reduction of hours of employment, 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 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 health flexible spending account plan, continuation coverage is available through the end of the Plan Year in which the qualifying event occurred. COBRA continuation coverage is not available if the dollar amount of reimbursements paid to the covered employee exceeds the amount contributed to the plan by the covered employee for the plan year as of the date of the qualifying event.

If you are a participant in a group health plan and the qualifying event is the death of the employee, the 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. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

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, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. 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 COBRA continuation coverage. The disabled individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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 healthcare coverage to domestic partners, civil union partners and the children of such partners who are covered by the group healthcare 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 PLAN MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

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 employee 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 Web site, www.healthinfolaw.org/state.

This notice is effective May 1, 2019.

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.

- "Healthcare 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 Inova Health System Office Benefits Department at the following address and phone number for more information on the Health Plan's privacy practices:

Inova Health System Office Benefits Department - HIPAA

8110 Gatehouse Road, 200W
Falls Church, Virginia 22042
(703) 205-2190