# Cleveland Guardians Baseball Co., LLC
# Health and Welfare Plan

# Plan Document and Summary Plan Description

# Effective Date: January 1, 2026

Package Version: 1
Form Edition: 37


© 2026 EZ ERISA LLC

This document constitutes both the formal Plan Document and also constitutes the Summary Plan Description for the Cleveland Guardians Baseball Co., LLC Health and Welfare Plan (referred to as the "Plan" in this document). The benefit plans and programs provided under the Plan are provided for employees of Cleveland Guardians Baseball Co., LLC (referred to herein as the "Employer" or "Company" in this booklet) and its controlled group members and/or affiliates as defined and stated in this document. The Plans and Programs of health and welfare benefits offered hereunder, are offered on an insured and/or self-insured basis, as stated herein and in Exhibit A. Certain plans and programs may be voluntary. All plans may be subject to required employee contributions. Eligibility and coverage and the specific plans and programs included in this Plan, which are incorporated as part of this Plan by reference, as stated in this Plan, are stated and referenced in detail, in Exhibit A.

The intent of this document is to satisfy the Employee Retirement Income Security Act of 1974 (ERISA) requirement for both a Plan Document under ERISA Section 402(a)(1) and the requirements of a Summary Plan Description ("SPD"), pursuant to ERISA Section 102. This entire document, including the specific insurance certificates of coverage, benefit booklets, and other information, as referenced in Exhibit A, are incorporated as part of this Plan, and all are subject to the discretion and interpretation of the Plan Administrator, except as specifically reserved for any insurer. All matters pertaining to rights and obligations with respect to the Plan, are subject to the Plan Administrator, except as may otherwise be specifically reserved or determined by an insurer under the contracts and certificates referenced in Exhibit A.

Although the Company's present intent is to continue this Plan indefinitely, please be advised and aware that the Company retains the absolute right to substitute other coverage, initiate and change employee contribution amounts as permitted by law, and amend, change, modify, and/or completely terminate some or all of the benefits, plans, programs and insurance coverage under this Plan, at any time. Neither this document nor any other writing regarding the Plan will grant or confer any vested or other rights to any employee, former employee or any other person for future benefits beyond amounts payable for periods of time while the Plan is in effect and that are not specifically provided for in the Plan terms.

The effective date of this restatement of the Plan is the Effective Date stated in Section 2.

TABLE OF CONTENTS

SECTION 1: PLAN INTRODUCTION 1
SECTION 2: BASIC INFORMATION 1
SECTION 3: ADMINISTRATION AND RELATED INFORMATION 2
3.1 Plan Funding and Constituent Benefit Programs 2
3.2 Type of Administration and Discretionary Authority 2
3.3 Plan Amendment and Termination 2
3.4 Claims Administrator 3
SECTION 4: PROGRAMS OF BENEFITS 3
4.1 Constituent Benefit Programs - Exhibit A 3
4.2 Wellness Programs 3
SECTION 5: ELIGIBILITY AND EFFECTIVE DATE 4
5.1 Who Is Eligible for Coverage 4
5.2 Effective Date of Coverage 5
SECTION 6: WHEN YOUR COVERAGE WILL END 6
SECTION 7: CLAIMS FOR BENEFITS, BENEFIT DETERMINATION AND CLAIM APPEALS 6
7.1 Claims for Benefits and Benefit Determinations 6
7.2 Important Terms 7
7.3 Claim and Appeal Procedures 8
a) Initial Claim for Benefits 8
b) Notice of Denial 8
c) Appeal of Decision 9
d) Final Determination 11
7.4 External Review (Only applies to Non-Grandfathered Plans.) 12
7.5 Time Limit to Appeal Denial of a Claim Will Be Strictly Enforced 14
7.6 Exhaustion, Process and Correction of De Minimis Process Matters 15
7.7 One Year Limit to File a Legal Action, Assignment 15
SECTION 8: RIGHTS OF REIMBURSEMENT AND SUBROGATION 15
SECTION 9: ACCESS TO RECORDS 16
SECTION 10: RECOVERY OF BENEFITS 17

SECTION 11: COBRA 17
11.1 Introduction, Default Language and Use 17
11.2 Qualified Beneficiaries 17
11.3 Qualifying Events 17
11.4 Required Notice of Qualifying Event 18
11.5 Election of COBRA Coverage 18
11.6 Rights and Obligations of COBRA-Covered Qualified Beneficiaries 18
11.7 Cost of COBRA Coverage 19
11.8 Maximum Length of COBRA Coverage 19
11.9 Termination of COBRA Coverage 19
SECTION 12: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 20
SECTION 13: NOTICE INFORMATION 20
13.1 General Notices 20
SECTION 14: GENERAL COMPLIANCE AND OTHER INFORMATION 21
14.1 No Vesting 21
14.2 HIPAA Rules, Policies and Procedures 21
14.3 USERRA Leave 22
14.4 FMLA Leave 22
14.5 No Employment Rights 22
14.6 Fraud or Concealment 22
14.7 Compromise of Claims 22
14.8 References and Inconsistencies 22
14.9 Applicable Law 23
SECTION 15: STATEMENT OF ERISA RIGHTS 23
SECTION 16: PLAN INTERPRETATION 24
SECTION 17: ADOPTION 24
Exhibit A - Constituent Benefit Programs 25
Exhibit B - Participating Employers 38

## SECTION 1: PLAN INTRODUCTION

The Company has adopted and established this Cleveland Guardians Baseball Co., LLC Health and Welfare Plan (which we will refer to as the "Plan") for the purpose of providing health and welfare benefits to eligible employees under a number of different benefit programs and arrangements that we refer to as the Constituent Benefit Programs.

This document, along with the Constituent Benefit Program documents that are incorporated into this document, establish the Plan for the Company and this Plan is intended to satisfy the Employee Retirement Income Security Act of 1974 (ERISA) requirements for both a Plan Document under ERISA Section 402 and a Summary Plan Description ("SPD"), pursuant to ERISA Section 102.

## SECTION 2: BASIC INFORMATION

| Description | Plan Information |
|---|---|
| Employer and Plan Sponsor: | Cleveland Guardians Baseball Co., LLC |
| Address: | 2401 Ontario Street, Progressive Field, Cleveland, OH 44115 |
| Telephone Number: | 216-420-4605 |
| Plan Administrator: | Cleveland Guardians Baseball Co., LLC at Address Stated Above |
| Other Participating Employers, if any: | See Exhibit B |
| Plan Name: | Cleveland Guardians Baseball Co., LLC Health and Welfare Plan |
| Plan Type and Funding: | The Plan Components are Funded by Insurance or Self-Funding including Employer and Employee Contributions as stated in Exhibit A. |
| Benefit Offering: | Constituent Benefit Programs as Described in Section 3.1 and as Shown on Exhibit A |
| Plan Number: | 501 |
| Agent for Service of Legal Process: | Cleveland Guardians Baseball Co., LLC at Address Stated Above |
| Employer Identification Number: | 34-1547452 |
| Type of Administration: | See Section 3.2 |
| Agent for Service of Process: | The Employer Listed Above, at the Address Above |
| Effective Date: | January 1, 2026 |
| Plan Year: | Twelve Month Period Beginning: January 1 |
| "Eligible Employee": | See Exhibit A |
| Spouse Restrictions in Group Health Plan: | Any Spousal Restrictions that applies to any Constituent Benefit Program is listed in Exhibit A |

# SECTION 3: ADMINISTRATION AND RELATED INFORMATION

## 3.1 Plan Funding and Constituent Benefit Programs

Funding. The Plan is funded primarily through the purchase of insurance, unless all or portions of the Plan are self-funded by the Company as stated in Exhibit A. Employees may be required to pay for a portion of the premium for coverage, as determined from time-to-time by the Employer. Continued eligibility is conditional upon the Employee authorizing and paying the required Employee contribution amount either from the Employee's pay or otherwise. The Employer will provide reasonable notice of the Employee contribution amounts, which can be at the time of benefits eligibility. If any rebates, credits, refunds or other amounts are paid back, or made available from insurers, administrators, or others, such amounts are paid to the Employer to offset the Employer's cost to provide and/or administer benefits under the Plan.

"Constituent Benefit Programs." The policies and contracts of insurance are referred to as "Constituent Benefit Programs." The Constituent Benefit Programs are referenced and stated in Exhibit A to this Plan document, and each of the Programs is incorporated into this Plan and SPD by reference. The Constituent Benefit Programs that are in the form of insurance certificates of coverage or insurance contracts, supersede this Plan and SPD with respect to eligibility, coverage and the payment of benefits, unless this Plan states otherwise specifically. If there is any conflict between the terms of the Constituent Benefit Programs and this Plan and SPD, the Plan Administrator will reconcile such inconsistency and has full rights to do so, as further provided under this Plan and SPD. See also Section 4.1.

## 3.2 Type of Administration and Discretionary Authority

The Plan is administered by the Claims Administrators and the Plan Administrator in accordance with the provisions of the Plan and the Constituent Benefit Programs, as listed and provided for in Exhibit A or the relevant Constituent Benefit Program under the Plan.

When a Constituent Benefit Program is insured, the insurance provider is the Claims Administrator and is directly responsible as the fiduciary for claims and claim determinations under each such insured Constituent Benefit Program under the Plan. When a Constituent Benefit Program is self-insured, the third-party administrator is the Claims Administrator and is directly responsible as the fiduciary for claims and claim determinations under each such self-insured Constituent Benefit Program, unless specified otherwise. When a claim determination is delegated to or is the responsibility of the Claims Administrator under the Plan, the Plan Administrator is not the responsible fiduciary. When a determination on a claim, or eligibility, or other term, or of fact, law or interpretation under the Plan is not specifically reserved to an insurer or third-party administrator, it is the fiduciary responsibility of the Plan Administrator for such determination under the Plan. When the Plan Administrator is the responsible fiduciary, or there is a third-party fiduciary, the Plan Administrator and such third-party, as the case may be, have full discretionary authority with respect to all determinations under this Plan, including the determination of the identity of the responsible fiduciary, the facts, the interpretation of the Plan or its terms and all decisions and determinations under this Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law.

The Plan Administrator may delegate duties and responsibilities to others in its absolute discretion, including without limit, third-party administrators, consultants, accountants, legal counsel, and/or Committees, or others.

## 3.3 Plan Amendment and Termination

Amendment. The Employer may amend or alter the provisions of the Plan, or any of the Constituent Benefit Programs, at any time, by any action of the Company taken in the normal course of its business. This includes, without limitation, any action by an officer or employee of the Employer or any individual designated in writing by such an officer as authorized to take such action. Any such amendment will be effective at the time designated in the amendment.

Termination. The Company may discontinue or terminate the Plan, in whole or in part, at any time whatsoever, by any action in the normal course of business, including without limitation, by written action of the Company in accordance with its operating documents and/or applicable state law. Any such termination will be effective at the time designated in such documentation.

### 3.4 Claims Administrator

Claims Administrators are the insurers under the separate Constituent Benefit Programs under the Plan, as incorporated in Exhibit A to this Plan. See Section 3.2.

## SECTION 4: PROGRAMS OF BENEFITS

### 4.1 Constituent Benefit Programs - Exhibit A

The benefits, rights and responsibilities are provided for under the various welfare benefit programs called "Constituent Benefit Programs." The Constituent Benefit Programs are incorporated in this Plan by reference and are stated in Exhibit A. The specific terms and conditions of each of the Constituent Benefit Programs are described in the documents listed in Exhibit A and together, along with this Plan Document and Summary Plan Description, form the Plan.

Each of the Constituent Benefit Programs is represented by a writing, including any insurance contract, benefit booklet, certificate and/or other documents referenced in Exhibit A, and each of them is incorporated as part of this Plan by reference and are part of this Plan.

### 4.2 Wellness Programs

If a Constituent Benefit Program under the Plan, as listed on Exhibit A, is a wellness program or includes a wellness program, it will be reasonably designed to promote health and prevent disease. The wellness program may involve a reward or surcharge that applies to the amount that the Eligible Employee will have to pay for coverage under the Plan. When a wellness program involves a reward or surcharge that relates to any "health factor" as that term is used under ERISA ("Wellness Reward Program"), certain rules apply:

- The Employer and/or Plan Administrator may establish and administer the Wellness Reward Program directly, or with the use of a third party provider or consultant as they may determine.
- The Eligible Employee's participation in the Wellness Reward Program will provide for an annual opportunity to qualify for the reward (or to avoid a surcharge as applicable), and the amount of such reward or surcharge will not exceed thirty percent (30%) (fifty percent (50%) in the case of a tobacco related Program) of the cost of employee only coverage (or employee and dependent coverage if the dependent is included in the Program) provided under the Plan.
- The reward or surcharge shall apply to all covered individuals in the Plan on an equivalent basis.
- The Wellness Reward Program will specifically provide for the availability of a reasonable alternative standard, including the possibility of a waiver of the otherwise applicable standard, in writing. In the event that any Wellness Reward Program materials do not so provide a reasonable alternative, this SPD is considered notice to each Eligible Employee and Dependent as applicable that a reasonable alternative will be provided to each such affected Eligible Employee (and Dependent as applicable) covered by the Plan, and such covered persons may contact the Plan Administrator for a specific reasonable alternative that applies, or that shall apply to such covered person to reasonably accommodate their specific circumstances.

# SECTION 5: ELIGIBILITY AND EFFECTIVE DATE

## 5.1 Who Is Eligible for Coverage

In General. The coverage described in this Plan is provided to the Employees of the Employer as detailed in the attached Exhibit A, along with their designated Spouses and their Dependents, as may be applicable. Existing employees may be subject to certain open enrollment periods for eligibility or changes in coverages, as determined by the Employer. Other eligibility periods may apply as required by law. Certain Employees are not eligible under the Plan. Employees are not eligible for all or certain of the Constituent Benefit Programs under the Plan, if they are not designated as Eligible Employees by the Employer in Exhibit A. Employees subject to collective bargaining are only Eligible if the terms of such bargaining agreement provides for their inclusion in this Plan. Leased employees are not covered by this Plan, unless the Employer specifically grants coverage for leased employees through its agreement with any employee leasing company. Independent contractors are not Employees eligible under this Plan.

Requirements. Employees may be required to satisfy certain requirements for eligibility under the Plan. Eligibility for Employees are specified in Exhibit A. In addition, as a condition for coverage to apply, Employees are required to pay the Employee contribution amounts that may be required by the Employer, from time to time, with respect to each of the Constituent Benefit Programs, and must authorize such payments to be made. Also, coverage is conditional upon the Employee providing any required information or completing any required forms. For certain dates and times prior to the effective date of this Plan, Employees and former Employees may be subject to entry dates and eligibility terms that are different and that apply to such prior periods of employment.

Reasonable Determination Periods – Variable Hour, Seasonal and Temporary Employees. When the benefit is a group health plan that as determined by the Plan Administrator is subject to the eligibility rules and regulations for group health plans, the Company will reasonably comply with such rules. When the Company cannot determine that a newly hired variable hour, part-time, seasonal or temporary Employee (a “Variable Hour Employee”), who is in an eligible class of employees, will satisfy the working full-time eligibility requirements under the group health plan, as stated in the relevant Exhibit A, the Plan Administrator will apply reasonable determination periods to determine if the Variable Hour Employee is eligible. The Company will establish a measurement period, not to exceed 12 months, applicable to such Variable Hour Employee or class of such employees and will undertake a measurement of the employee’s hours during that measurement period. If the employee meets or exceeds the hours requirement, then the Company will offer coverage to the Variable Hour Employee during a stability period that follows, which will comply with the applicable regulations. Once the Company determines that such Variable Hour Employee has met the hours requirement, the Employee will be eligible under rules established by the Company that follows the applicable regulations, which generally is no later than the first day of the month coincident with, or that immediately follows the measurement period, with such eligibility date being no later than 13 months from the first day of the month following start of the period. The Company has discretion to determine the measurement and stability periods and entry dates consistent with the applicable regulations.

Other Benefit Programs. With respect to insured and self-funded benefits that are not group health plans, the Company will reasonably determine, consistent with the applicable terms of the Constituent Benefit Program, whether an Employee meets the relevant eligibility requirements, including any consultation with the insurer or administrator as deemed necessary.

"Spousal Exclusion." If the Spousal Exclusion is indicated in Exhibit A, special rules apply to Spousal coverage under this Plan as stated in this section. When the Spousal Exclusion applies, the Plan generally excludes Spouses of Employees altogether, or excludes Spouses who have coverage available to them from some other source. If the Spousal Exclusion applies to a Constituent Benefit Program under the Plan, it will be so indicated in that Program or in Exhibit A. If indicated and your Spouse has Other Coverage (as defined below), your Spouse must be enrolled in those plans and they cannot participate in the Constituent Benefit Programs as indicated in that Program, or in Exhibit A.

Available Other Coverage for the Spouse may be determined and confirmed by means of a written statement in a form determined by the Plan Administrator.

If your Spouse coverage eligibility or participation status changes, you must notify the Plan Administrator, in writing, of this change as soon as possible, but not later than 5 business days after its occurrence.

"Spousal Limitation." If the Spousal Limitation is indicated in Exhibit A, special rules apply to Spousal coverage under this Plan, as stated in this section. When a Spousal Limitation applies, the applicable Constituent Benefit Program generally limits coverage of the Spouse of any Employee, or limits coverage when the Spouse has coverage available to them from some other source. If the Spousal Limitation applies to a Constituent Benefit Program under the Plan, it will be so indicated in that Program and/or in Exhibit A. If your Spouse has "Other Coverage" (as defined below), your Spouse must be enrolled in such Other Coverage and they cannot be covered by the Constituent Benefit Programs with such Limitation, unless you pay a Covered Spouse Premium. The Covered Spouse Premium amount is an additional premium or required Employee contribution amount that applies to Spouses who have Other Coverage. Such Covered Spouse Premium amount is periodically determined by the Employer. Such Spousal Coverage may also only be secondary coverage, if this is indicated in Exhibit A.

If the Employee's Spouse has no Other Coverage available, then the Spouse is eligible under the Constituent Benefit Programs where the Covered Spouse Limitation applies. Available coverage for the Spouse will be determined and confirmed by means of a written statement in a form determined by the Plan Administrator.

If your Spouse coverage eligibility or participation status changes, you must notify the Plan Administrator, in writing, of this change as soon as possible, but no later than 5 business days after its occurrence.

Other Definitions: As used herein, the following terms are defined as stated below:

*"Dependent" Defined:* Except as otherwise specified in Exhibit A, or the applicable Constituent Benefit Program, the "Eligible Dependents" under the Plan include each (i) Spouse of a Participant, (ii) Eligible Child of a Participant, (iii) other Dependent of a Participant within the meaning of Section 152 of the Internal Revenue Code who is eligible for coverage under a Constituent Benefit Program, and (iv) any other individual who is eligible for coverage under a particular Constituent Benefit Program. See Exhibit A.

*"Spouse" Defined:* Except as otherwise specified in Exhibit A or the applicable Constituent Benefit Program, a "Spouse" is the legal Spouse of an Eligible Employee as defined by applicable state law, except that such term does not include (i) a common law spouse unless any and all documentation or registration of the common law marriage required by the Plan Administrator, in its discretion, has been filed with the Plan Administrator or (ii) a Spouse who is an Employee. In the event that the Spouse is an Employee, the Employer will determine a policy to determine how coverage will apply with respect to each Constituent Benefit Program.

*"Child" Defined:* Except as otherwise specified in Exhibit A or the applicable Constituent Benefit Program, a "Child" is defined as the legally recognized offspring of a Participant, as recognized by the state law where the Employee or other covered person resides. A "child" includes those recognized through a legal adoption process. A "Child" under the Plan does not include a Child who is an Employee. The final determination of a child is subject to the discretion of the Plan Administrator.

*"Other Coverage" Defined:* "Other Coverage" is coverage that is available to the Spouse from some other source, such as the Spouse's employer, a retiree benefit program, certain governmental benefits, veterans benefits, or otherwise.

## 5.2 Effective Date of Coverage

Your coverage will become effective as provided in this Plan and under each of the Plan's Constituent Benefit Programs, as provided in this Plan. No benefits are payable unless you are an Eligible Employee and have met the requirement to be eligible and covered under a Constituent Program under the Plan. Eligible Entry date also applies to changes in status. Please note that you must have submitted any required enrollment form, or any other required documentation in order to obtain coverage under a Constituent Benefit Program.

## SECTION 6: WHEN YOUR COVERAGE WILL END

Subject to continuation of coverage rights under COBRA (see below for full explanation of COBRA rights, if it applies to the Employer and to the type of health or welfare Constituent Benefit Program), your coverage under the Plan will end on the last day of coverage, as provided under the Constituent Benefit Programs. Some coverage may end on the last day of the month following your termination of employment or retirement, if such termination is provided for under the particular Constituent Benefit Program. Other coverage will end on your last day of employment. If the Constituent Benefit Program does not so provide terms for the end of coverage, then your coverage will end on:

- your last day of active work (with coverage provided through the end of your last day of active work);
- your last day of active work immediately preceding the day you are considered as laid off from the Employer;
- your last day of active work immediately preceding the day you are considered as retired from the Employer;
- the day you have a change in employment status that results in your ceasing to meet the then applicable eligibility requirements of one or more of the Constituent Benefit Programs, unless specific terms of leave provided by the Employer otherwise provide for continued eligibility;
- your last day of active work immediately preceding your transfer to an ineligible status;
- any day upon which you fail to authorize or make any employee contribution or other payments required for coverage;
- the day of your death; or
- the day the Plan terminates.

Except as provided in Exhibit A otherwise, there is no severance or retiree coverage under the Plan, whatsoever.

*Notice of Conversion Rights.* Certain of the Constituent Benefit Programs that are insured, may be subject to certain conversion rights. This means that you may have the right to convert your rights under the group insurance policy to an individual policy. These rights vary from policy to policy and may also vary from state to state. You are notified of such rights with respect to each such Constituent Benefit Program on behalf of the Employer and you should take action accordingly if you wish to exercise such rights.

*Suspension of Benefits.* The Plan Administrator and any Claims Administrator, or delegate, may suspend benefits, eligibility, or payments in the event that the Plan Administrator, Claims Administrator or delegate determines, in their sole and absolute discretion, that entitlement to benefits is in debt.

## SECTION 7: CLAIMS FOR BENEFITS, BENEFIT DETERMINATION AND CLAIM APPEALS

### 7.1 Claims for Benefits and Benefit Determinations

Each Participant or beneficiary claiming a benefit under the Plan must follow the claim and appeal provisions in the Constituent Benefit Program under which a benefit is claimed. Claims for benefits are to be filed and/or submitted as provided for under the terms of the applicable Constituent Benefit Program but no later than 1 year from the date the claim is incurred. Appeals of any denial of benefits are also filed under the terms of the Constituent Benefit Program that applies. However, in the event that any of the Constituent Benefit Programs do not include a claim and appeal procedure, or include a procedure that is determined by the Plan Administrator in its sole discretion to be incomplete or not in compliance with current law, or there are any questions or inconsistencies that exist in any of the Constituent Benefit Programs, then this claims procedure and procedure for appeals - or a "Review on Decision" will apply.

When the Constituent Benefit Program includes a claims procedure that is not determined by the Plan Administrator to be incomplete or not in compliance with current law, the Claims Administrator, not the Plan Administrator, will process and decide such a claim. Only when these claims procedures are deemed to apply, as stated herein, does the Plan Administrator or its designee, make these determinations.

Certain provisions that relate to disability benefit claims are amended to be effective for claims for disability benefits filed under a Constituent Benefit program that provides disability benefits after April 1, 2018. Such provisions are indicated in this procedure and are subject to the determination by the Plan Administrator regarding application of such provisions as stated above. The phrase "disability benefit claims *after April 1, 2018*" means for all claims for disability benefit filed after April 1, 2018 under a Constituent Benefit Program that provides for disability benefits.

## 7.2 Important Terms

*Adverse Benefit Determination*. An "Adverse Benefit Determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and in the case of a plan providing disability benefits, the term "Adverse Benefit Determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or a denial, reduction, or termination of, or a failure to provide or make payment for (in whole or in part), a benefit.

Effective for disability benefit claims *after April 1, 2018*, an "Adverse Benefit Determination," in the case of a plan providing disability benefits, also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). The term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

*Claim*. A "Claim" under the Plan is a request for benefits under a Constituent Benefit Program made by a Claimant in accordance with the procedure for filing benefit claims. All Claims must be filed as specified in this Plan. Claim appeals on Adverse Benefit Determinations must be in writing.

*Claimant*. A "Claimant" is the Plan participant filing a Claim. A personal representative may be authorized to act on behalf of a Claimant. This authorization must be in writing and signed by the Claimant.

*Claim File*. A "Claim File" means the file or other compilation of "Relevant" information, which includes information that: 1) was relied upon in making the benefit determination; 2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; 3) demonstrates compliance with the administrative processes and safeguards as provided in this procedure; or 4) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

*Claims Administrator*. The "Claims Administrator" for the Plan is the party designated in the Claims Appeal section of each Constituent Benefit Program's Plan as applicable.

*Constituent Benefit Program*. A "Constituent Benefit Program" is each separate health or welfare benefit program described in this Plan, as defined herein.

*Plan Administrator*. The "Plan Administrator" for the Plan is the Employer.

*Primary Contracts*. The "Primary Contract" for a Constituent Benefit Program is stated in such Constituent Benefit Program documentation attached and incorporated as part of this Plan Document and SPD.

### 7.3 Claim and Appeal Procedures

In the event that the Claims Procedure stated herein applies, and it applies only when the Plan Administrator determines that the Constituent Benefit Program does not include a claims procedure, as provided in Section 7.1 above, the following claim and appeal process is to be followed.

a) Initial Claim for Benefits

*Filing of Claim*. A claim for benefits under the Plan will be filed, in writing, with the Plan Administrator.

*Notice of Denial*. If a claim is for post service, or certain concurrent non-urgent service claims for benefits under the Plan is wholly or partially denied, except as otherwise provided herein, the Plan Administrator will, within 30 days after receipt of the claim, notify the Claimant of the denial of the claim. Such 30-day period may be extended for no more than an additional 15 days if the Plan Administrator determines that an extension of time for processing the claim is necessary due to matters beyond the control of the Plan, in which case the Plan Administrator will notify the Claimant of the extension in writing within the initial 30-day period, and such notice of extension will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

*Urgent Health Claims (Medical Claims Only)*. Urgent health claims will be decided as soon as possible within 72 hours rather than within 30 days. The 72-hour deadline may not be extended. An urgent health claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

*Pre-Service Health Claims (Medical Claims Only)*. Pre-service health claims will be decided within 15 days rather than 30 days. The 15-day deadline may be extended by an additional 15 days. A pre-service health claim is any claim for a benefit with respect to which Plan terms condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

*Disability and Other Claims*. Disability and Other claims will be decided within 45 days rather than 30 days. The 45-day deadline may be extended by an additional period of 45 days.

If an extension of time is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice within which to provide the specified information. If the request for information is made after the initial period, then the Plan Administrator may toll the deadlines stated, until the Claimant submits the requested material.

b) Notice of Denial

A notice of denial will be (a) in writing (or in electronic form); (b) written in a way to be understood by the Claimant; and (c) contain:

- the specific reason or reasons for denial of the claim;
- references to the specific Plan provisions upon which the denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- an explanation of the claim review procedure and the time limits applicable to such procedures, in accordance with the provisions of this Claim and Appeal Procedure; and

- a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA if the claim is denied upon review.

*Special Group Health Plan Rules*. In the case of an Adverse Benefit Determination by a group health plan, such plan will provide free of charge to the Claimant upon request:

- A copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination.

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances.

- In the case of an Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims. All information required to be provided may be done so orally within the time frames stated herein, provided that a written or electronic notice including the required information is furnished to the Claimant not later than 3 days after the oral notification.

*Special Disability Benefit Rules*. Effective for disability benefit claims *after April 1, 2018*, in the case of an Adverse Benefit Determination with respect to disability benefits, such determination will include a discussion of the decision, and as appropriate will include an explanation of the basis for disagreeing with or not following:

- The views presented by the Claimant to the plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

- A disability determination regarding the Claimant presented by the Claimant to the plan made by the Social Security Administration;

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's claim for benefits. See Claim File definition above; and

- The notification shall be provided in a culturally and linguistically appropriate manner.

c) Appeal of Decision

*Request for Review of Denial*. The Claimant may, within 180 days after receiving a written notice of denial of the claim, file a written request with the Plan Administrator that it conduct a full and fair review of the denial of the claim. The Plan Administrator will:

- provide the Claimant with the opportunity to submit written comments, documents, records and other information relating to the claim;
- provide the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the claim;
- effect a review of the denial that takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- provide a review that (a) does not afford deference to the initial Adverse Benefit Determination, (b) is conducted by a Plan fiduciary (the "reviewing fiduciary") who did not make the Adverse Benefit Determination and who is not the subordinate of the individual who made the Adverse Benefit Determination;
- provide that the reviewing fiduciary will, before deciding an appeal based in whole or in part on a medical judgment, consult with a health care professional having appropriate training and experience, who was not involved with the Adverse Benefit Determination and is not the subordinate of any such individual; and
- provide for the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination (regardless of whether the advice was relied upon).

*Special Disability Benefit Review on Decision Rules*. Effective for disability benefit claims after *April 1, 2018*, the Claimant will be afforded a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. As part of the determination on review, the Plan Administrator will provide to Claimant, free of charge:

- any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim and such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided under this section and the Claimant will be afforded a reasonable opportunity to respond prior to that date; and
- with the rationale for any Adverse Benefit Determination, and such rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided under this section to give the Claimant a reasonable opportunity to respond prior to that date.

*Decision on Appeal*. The Plan Administrator will deliver to the Claimant a decision in writing (or in electronic form) on the appeal within 60 days after the receipt of the Claimant's request for review, unless the claim category and type is described below.

- Urgent health appeals will be decided within 72 hours rather than 60 days and shall be transmitted by an expeditious method such as telephone or facsimile.
- Pre-service health appeals will be decided within 30 days rather than 60 days.
- Disability and other appeals will be decided within 45 days rather than 60 days.

*Extensions and Tolling*. The 60-day appeal deadline for non-urgent claims and the 45-day deadline for disability claims may be extended by an additional 45 days. In the event that information is requested from the Claimant, and if such a request is made or is pending after the initial deadline period, then the Plan Administrator may toll the applicable time periods relative to the claim, while waiting for information from the Claimant. Any extension of time sought hereunder is deemed reasonable under the Plan, but the Plan Administrator will provide a reasonable explanation to the Claimant as to why the extension of time is sought.

d) Final Determination

The Plan Administrator's written decision will:

- be written in a manner calculated to be understood by the Claimant;
- include the specific reason or reasons for the decision and contain references to the specific Plan provisions upon which the decision is based;
- state that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits; and
- state the Claimant may have a right to bring a civil action under Section 502(a) of ERISA;
- include any internal rule, guideline, protocol, or other similar criterion that was relied upon in an Adverse Benefit Determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
- include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request when an Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit; and
- include the following 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."

*Additional Final Determination Rules for Disability Benefits*. Effective for disability benefit claims *after April 1, 2018*, in the case of an Adverse Benefit Determination with respect to disability benefits, such determination will include a discussion of the decision, and as appropriate will include an explanation of the basis for disagreeing with or not following:

- The views presented by the Claimant to the plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
- A disability determination regarding the Claimant presented by the Claimant to the plan made by the Social Security Administration;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's claim for benefits. See Claim File definition above; and
- The notification shall be provided in a culturally and linguistically appropriate manner.

*Authorized Representative*. The Plan Administrator will permit an authorized representative of the Claimant to act on behalf of the Claimant under this claim and appeal procedure. The Plan Administrator may establish reasonable procedures for determining whether an individual who purports to be an authorized representative of a Claimant has in fact been authorized to act on behalf of such Claimant.

*Culturally and Linguistically Appropriate Notices*. Whenever the phrase: "culturally and linguistically appropriate" appears in this claims procedure, the following requirements apply:

- The plan will provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language.
- The plan will provide, upon request, a notice in any applicable non-English language.
- The plan will include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.
- For purposes of these rules, with respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

*Administrative Processes and Safeguards*. The Plan Administrator will develop such administrative processes and safeguards as it deems necessary to ensure and verify that claim determinations are made in accordance with the Plan and other governing documents, if any, and that where appropriate, the provisions of the Plan have been applied consistently with respect to similarly situated Claimants.

### 7.4 External Review

*Voluntary External Review*. This is a special default language for a procedure that applies only if the Constituent Benefit Program or Programs that form the group health plan has "non-grandfathered" status, or if they lose grandfathered status. In such a case, there is a voluntary external review process that applies, if the Claimant has exhausted the two levels of appeal (when required), and the Claimant is still not satisfied with the final determination. Voluntary external review applies only to the denial of medical, mental health/substance abuse, prescription drug, certain dental, or vision claim denials if the denial is based on one of the following:

1. Clinical reasons based upon medical judgment, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or if a treatment is experimental or investigational; or
2. Rescission (retroactive termination) of care.

External review does not apply with respect to claims based upon the eligibility of an Employee, Spouse or Dependent, or with respect to whether a particular claim involves a covered product or service. If you have any questions regarding the External Review, you may contact the Plan Administrator for more information about whether or not the voluntary external review program is available to you.

*Request for External Review*. A request for an external review generally must be made within four months following the day that you receive notice of the denial on appeal. Also, you can request an expedited external review as described in Expedited External Review below.

*Preliminary Review*. Within five business days of receiving your request for external review, the Plan Administrator will complete a preliminary review, which determines:

1. if you were covered under the Plan at the time of service;

2. that the review does not relate to your eligibility to participate in the Plan;

3. that your review meets the criteria for external review stated above; and

4. that you completed the Plan's internal appeals process to the extent required, and that you have provided all necessary information and forms for processing an external review.

You are not eligible for an External Review if the Claims Administrator determines that you have not met all of the above requirements. Within one business day after the initial review of your request, the Plan or Claims Administrator may provide you with a notice that includes the reasons your request does not meet the requirements for an External Review and contact information for the Employee Benefits Security Administration of the U.S. Department of Labor. The notice will describe information or materials needed to complete your request, if applicable.

Your deadline to complete the request is the end of the four-month period described above or, if later, 48 hours after you receive the notice that the request was not complete. If your request is expedited, the Plan Administrator will immediately consider the above criteria and notify you of the determination as described in Expedited External Review below.

*External Review by an Independent Review Organization (IRO)*. If your request qualifies for external review, it will be assigned to one of the qualified Independent Reviewer Organizations (IRO) with which the Claims or Plan Administrator has a contract. Within five business days after assigning the request to the IRO, the Claims or Plan Administrator will provide the IRO with the documents and information that were considered in the denial. If the Claims or Plan Administrator does not provide this information, the IRO may end the external review and reverse the Claims or Plan Administrator's decision. If this occurs, the IRO will notify you and the Claims or Plan Administrator within one business day of this action.

The IRO will give you written notice of the request's acceptance for external review. The notice will include a statement that you have 10 business days to submit additional written information. The IRO will consider this information in its review. The IRO also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from you, the IRO will forward the information to the Claims or Plan Administrator, which may reconsider the denial on appeal based on this additional information. If the Claims or Plan Administrator decides to reverse the denial on appeal and provide coverage or payment, written notice will be provided to you and to the IRO within one business day of the decision. The IRO's external review will end if this notice is received.

If the Claims or Plan Administrator does not provide any notice of reversal of the decision, the IRO will review all information and documents submitted by the deadline. The IRO must review each claim without being bound by or subordinate to any decisions or conclusions reached during the entire prior claims and appeals process.

In addition to the documents and information provided by you and the Claims Administrator, the IRO will consider the following information or documents if they are available and the IRO considers them appropriate:

1. Your medical records;

2. Your attending health care professional's recommendation, reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;

3. Plan terms, unless the terms are inconsistent with applicable law;

4. Appropriate practice guidelines, which include applicable evidence-based standards;

5. Any applicable clinical review criteria developed and used by the Administrator involved, unless the criteria are inconsistent with Plan terms or applicable law; and

6. The opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The IRO will provide written notice of the decision to you and the Administrator involved within 45 days after the IRO receives your request. This notice may contain, if relevant:

1. A general description of the reason for the request and information that identifies the claim such as the date(s) of service, health care provider, and claim amount (if applicable);
2. A statement describing the availability, upon request, of the diagnosis code and/or treatment code (and their corresponding meanings);
3. The reason for the prior denial;
4. The date the IRO received the request and the date of the decision;
5. References to the evidence or documents (including the specific coverage provisions and evidence-based standards) considered in reaching the decision;
6. A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
7. A statement that the IRO's determination is binding, unless other remedies are available under state or federal law;
8. A statement that judicial review may be available to you; and
9. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsmen.

If the Plan Administrator receives notice from the IRO that reverses a denial, the Plan Administrator will immediately provide or authorize coverage for or payment of the claim. The IRO will maintain records of all claims and notices associated with the outside review process for six years and make these records available for examination by you, the Claims Administrator or a state or federal oversight agency upon request (except where disclosure would violate state or federal privacy laws).

***Expedited External Review***. An urgent care claim or urgent health appeal is determined as such by the attending provider. In such case, for notification of the Plan's benefit determination (whether adverse or not) must be completed as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

### 7.5 Time Limit to Appeal Denial of a Claim Will Be Strictly Enforced

Regardless of whether the Constituent Benefit Program provides for time limits to appeal, this provision applies. The limits for a Claimant to file an appeal after an initial denial of a Claim for benefits and to file a final appeal will be strictly enforced. If a Claim is initially denied and the Claimant does not request a review within the time limit after receipt of that determination, the Claimant will forfeit his or her right to request a review of this determination.

If a Claimant does not make an appeal within the time limit after receipt of the initial denial, the Claimant will forfeit his or her right to final appeal.

The Plan Administrator may at all times, consistent with the applicable regulations, toll the timing of any claim or appeal, or may extend the deadlines of such claim or appeal process, if the Plan Administrator determines in its sole discretion that such toll or extension is reasonable under the circumstances.

If a Claimant does not make a final appeal within the time limit after a determination, the Claimant will lose his or her right to file an action in federal or state court because the Claimant will not have exhausted his or her administrative remedies.

Effective for disability benefit claims *after April 1, 2018*, subject to the terms of Correction of De Minimis Process as stated in Section 7.6, if the plan fails to strictly adhere to all of the claim decision and review on decision requirements stated in Section 7, the Claimant is deemed to have exhausted the administrative remedies and the Claimant is entitled to pursue remedies under ERISA Section 502(a) on that basis and in such case, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

### 7.6 Exhaustion, Process and Correction of De Minimis Process Matters

In the event that during the claim or appeal process, either the Plan or the Claimant fails to strictly follow the requirements of the claim or appeal procedure, the affected party shall notify the other in writing and provide for a reasonable opportunity to cure the failure. Any failure of process deemed de minimis, or not, that may be corrected so that there is no prejudice or harm to the Claimant, determined to have occurred by good cause, or beyond the control of the Plan or the Claimant where such violation occurred in the context of an ongoing good faith exchange of information, will be corrected and such correction will be deemed a complete correction of any process defect and not an exhaustion of remedies.

In the event that the Plan or Claimant believes that a defect in process has occurred, the affected party shall notify the other in writing. A response to such assertion shall be provided in 10 days from the date of receipt and such response shall include a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted, and may include the corrective actions taken.

Effective for disability benefit claims *after April 1, 2018*, in the event that any court rejects the Claimant's assertion that remedies were exhausted, the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission and the Appeal of Decision provisions shall apply and commence with respect to such claim.

### 7.7 One Year Limit to File a Legal Action, Assignment

If the Plan Administrator denies a Claim on appeal, the Claimant has the right to file suit in federal court under ERISA Section 502(a). However, no legal action for recovery of benefits allegedly due under the Plan may be commenced by or on behalf of a Claimant against the Plan, the Plan Administrator or any other Plan fiduciary, Claims Administrator or other Third Party Administrator unless it is filed within one year after the date of the final determination by the Plan Administrator under the Claims Appeal Procedure described herein.

No rights under this Plan may be assigned, unless such assignment is specifically permitted under the applicable Constituent Benefit Program.

## SECTION 8: RIGHTS OF REIMBURSEMENT AND SUBROGATION

If the Employer pays benefits under a Program which is the result of an event: (a) caused by the act or omission of another party; or (b) sustained on the property of a third party which has premises liability insurance available, the Employer, or the Claims Administrator on behalf of the Employer (or on its own behalf if the Claims Administrator is an insurer), has the right to recover benefit payments made under the Plan. Reimbursement means the Employee must repay the Employer at the time the Employee makes any recovery. Recovery means all amounts received by the Employee from any persons, organizations, or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Employer, or the Claims Administrator or other third party acting on behalf of the Employer, may make a claim in the name of the Employee or in the name of the Employer or Plan Administrator, as applicable, against any persons, organizations or insurers on account of such injury or illness. The Plan Administrator or Claims Administrator, if applicable, have full remedial rights, including the right to initiate actions, declaratory judicial actions, or to take any action deemed appropriate.

The rights of reimbursement and subrogation apply whether or not the Employee has been fully compensated for the Employee's losses or damages by any recovery of payments. In the event the Employee settles a claim against a third party, the Employee is deemed to have been made whole by such settlement and the Employer, or the Claims Administrator or other third party acting on behalf of the Employer, will be entitled to immediately collect the present value of its subrogation rights as the first priority claim from said settlement or judgment. The Employer is entitled to the first dollars recovered. No attorney's fees will be payable from any subrogation recovery unless the Employer has been notified of the attorney's proposed representation in advance and the Employer has agreed in writing to the representation of the Employer's interests by that attorney. Under certain circumstances, the Employee will be required to hold the Employer harmless against future benefit payments due to the injury or illness for which a settlement is reached.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. Any amounts the Employee receives from such a recovery must be held in trust for the Employer's benefit to the extent of the Employer's subrogation claims. Any amounts received in this regard, even if maintained in an attorney's trust account, or otherwise, shall be deemed held in trust or in a constructive trust for the benefit of the Plan and the recovery of benefits hereunder.

By filing a Claim for benefits under the Plan, the Employee must cooperate fully in every effort by the Employer, or the Claims Administrator or other third party acting on behalf of the Employer, to enforce the Employer's rights of reimbursement and subrogation. The Employee must not do anything to interfere with those rights. The Employer will have the right to discontinue the payment of benefits in the event that the Employee fails to cooperate and to seek reimbursement from the Employee for the amount of benefits paid due to that injury or illness. The Employee agrees to promptly inform the Claims Administrator in writing of any situation or circumstance which may allow it to invoke the Employer's rights under this section.

## SECTION 9: ACCESS TO RECORDS

By filing a Claim for benefits under the Plan, each Eligible Employee, Spouse and Dependent authorizes the Employer, Claims Administrator, and their representatives (collectively the "Administrators") to access any records, health records or medical information held by any health care provider and employment information held by any employer. Authorization applies to the Administrators use of health records, medical information and employment information for: claims evaluation and processing including, without limitation, claims by the Employer for reimbursement or subrogation under the Plan; disability claims data evaluation; and evaluation of potential or actual claims against the Administrators, and any other matter in respect of payment of claims under the Plan.

Any person filing a claim under the Plan may be asked to complete an authorization under HIPAA for such purpose and the payment of claims may only be made if authorization is permitted. Such authorization is deemed part of the claim process. See Section 14.2 below.

## SECTION 10: RECOVERY OF BENEFITS

If any benefit payments are made in excess of the amount any Eligible person receives under the Plan, the Plan has a right to recover such payments. Such instances of overpayment may include erroneous payments; any payments made for any periods or events for which the Eligible person fails to satisfy the Plan or Constituent Benefit Program requirements; or any payments that are not reduced by amounts as specified in the applicable Plan or Constituent Benefit Program. When any circumstance arises where payments are made under the Plan in excess of the amount that the Eligible person is entitled to receive, the Employer and the applicable insurer or Claims Administrator have the right to recover all excess payments of any amounts, from any source, regardless of whether it is related to the Employee, Spouse or Dependent. All excess payments will be recovered directly from the recipient, or if necessary, from future benefit payments, or from the estate or other assets of the Eligible person who received the overpayment, to the extent permitted by law. In this regard, the Eligible person who received an overpaid benefit agrees to cooperate fully with the collection and return of any excess benefit payments, and the location where any excess payments were deposited or held is deemed a trust or constructive trust for purposes of the recovery of overpaid amounts. This includes any bank account, trust account, investment account or otherwise and the Plan has an interest in such amounts for purposes of such recovery.

## SECTION 11: COBRA

### 11.1 Introduction, Default Language and Use

The purpose of this Section 11 is to provide default provisions for extended health coverage, to the extent that the Consolidated Omnibus Budget Reconciliation Act of 1985, ("COBRA") applies with respect to the group health plan sponsored by the Employer, and any Constituent Benefit Program that is a group health plan (medical plan) lacks language that is sufficient for such purpose, as determined by the Plan Administrator in its sole discretion.

In general, COBRA coverage only applies to extend health coverage for employer sponsored group health plans, when such Employer generally employs more than 20 Employees during the relevant testing period. If the Employer is a smaller company, it may not be subject to COBRA, and this Section 11 only applies if the Employer is legally required to provide COBRA coverage.

COBRA coverage applies if a "Qualified Beneficiary" (as defined below) loses his or her coverage under any Constituent Benefit Program under the Plan that is a group health plan, and coverage is lost as a result of a "Qualifying Event" (as defined below). In such case the Qualified Beneficiary has the opportunity to continue health coverage for up to 18, 29, or 36 months (the time limit depends on the reason coverage ended as described below). The benefit programs under the Plan that are "group health plans" for purposes of COBRA coverage are any group health or medical plans providing inpatient and outpatient hospital care, physician care, surgery and other major medical benefits, prescription drug coverage, dental and vision care, and would include health savings or health reimbursement accounts that provide for the reimbursement of such items.

### 11.2 Qualified Beneficiaries

You and any of your Eligible Dependents who are covered by a group health plan on the day before coverage would otherwise end are known as "Qualified Beneficiaries." A "Qualified Beneficiary" also includes (1) any child who is born to or placed for adoption with you during your COBRA coverage period and (2) any individual who is not covered by the group health plan on the day before coverage would otherwise end if such individual's lack of coverage is solely the result of a violation of applicable law.

### 11.3 Qualifying Events

If your Eligible Dependent is a Qualified Beneficiary and loses coverage as a result of any of the following events, those events are considered "Qualifying Events" entitling that Qualified Beneficiary to COBRA coverage:

- Termination of your employment (other than by reason of gross misconduct, as determined by the Employer), including retirement;
- Reduction in your scheduled work hours;
- Your death while covered under the group health plan;
- Your divorce or legal separation from your Spouse while covered under the group health plan;
- Your Eligible Child's termination of "Eligible Dependent" status under the terms of the group health plan (because of, for example, attainment of age or loss of student status); or
- Your becoming entitled to Medicare.

COBRA coverage may also be available if the Employer files for bankruptcy and you and your Eligible Dependents lose coverage under a retiree medical program maintained by the Employer. In the event of such a "Qualifying Event," the Plan Administrator will notify you of your election rights.

### 11.4 Required Notice of Qualifying Event

If the Qualifying Event is divorce, legal separation, or loss of dependent status, you or your Eligible Dependent must notify the Plan Administrator, in writing, within 60 days of the later of (1) such Qualifying Event or (2) the resulting loss of health coverage. ***If you or your Eligible Dependent fail to notify the Plan Administrator within this 60-day period, the right to COBRA coverage will be lost***.

If the Qualifying Event is your termination of employment, reduction in hours, death, or entitlement to Medicare, or if the Plan Administrator is notified of a Qualifying Event described in the previous paragraph, the Plan Administrator will notify each Qualified Beneficiary of the right to continue coverage. Your duty to elect COBRA coverage, if you desire such coverage, does not arise until the Plan Administrator sends such notice.

### 11.5 Election of COBRA Coverage

Once the Plan Administrator is notified regarding the Qualifying Event, an event notification letter and a COBRA enrollment form will be sent to the last known address of each Qualified Beneficiary. *Please notify the Plan Administrator (or COBRA Administrator, if applicable) of all address changes*. If you desire COBRA coverage, you must return the properly completed enrollment form to the Plan Administrator no later than 60 days from the later of (1) the date coverage is lost due to the Qualifying Event or (2) the date you received notification (the "60-day COBRA Election Period"). Each Qualified Beneficiary has a separate election right and may choose to continue single coverage for himself or herself. The Plan Administrator will not be responsible for the receipt of COBRA forms sent by regular U.S. mail. ***If you do not elect COBRA coverage within this 60-day period, your right to elect COBRA coverage will be lost***.

### 11.6 Rights and Obligations of COBRA-Covered Qualified Beneficiaries

A Qualified Beneficiary who elects COBRA coverage has the same rights and obligations under the terms of the Plan as those provided to participants, including the right to enroll family members who would qualify as Eligible Dependents.

## 11.7 Cost of COBRA Coverage

You will be charged a COBRA premium equal to the full cost (as determined by the Plan Administrator) of your COBRA coverage, plus a 2% administration fee. Since coverage is retroactive to the date of the Qualifying Event, you will be required to pay for coverage that is retroactive to the date of the Qualifying Event. This premium must be paid within 45 days after your COBRA enrollment form is received. Additionally, in accordance with normal insurance billing procedures, you will be required to pay the next month's premium. This initial payment and all subsequent monthly premium payments must be paid in a timely manner. ***If any COBRA premiums are not paid within the required time periods, coverage will be terminated. Once terminated, COBRA coverage cannot be reinstated***.

## 11.8 Maximum Length of COBRA Coverage

If the Qualifying Event is termination of your employment or reduction in your scheduled work hours, the maximum length of COBRA coverage for you and your Dependent Qualified Beneficiaries is 18 months.

If the Qualifying Event is your death, divorce from your Spouse, termination of an Eligible Child's Eligible Dependent status, or your becoming entitled to Medicare, the maximum length of COBRA coverage for your Dependent Qualified Beneficiaries is 36 months.

If you become entitled to Medicare before your termination of employment or reduction of hours, and you elect Medicare coverage, your Eligible Dependents who are Qualified Beneficiaries, if any, may elect to continue coverage for the greater of 36 months from the date you become entitled to Medicare or 18 months from the date of your termination or reduction in hours.

*Special Length of Coverage Rule for Disabled Qualified Beneficiaries*

The maximum period of COBRA coverage available at termination of employment or reduction of work hours is increased from 18 months to 29 months with respect to individuals who are disabled at the time of such a Qualifying Event. The extended coverage period is available if the disabled Qualified Beneficiary:

- Is determined to have been disabled under Title II or XVI of the Social Security Act, for Social Security purposes, at any time during the first 60 days of COBRA coverage; and
- Gives the Plan Administrator notice of such determination, in writing, no later than 60 days after the date of the notice by Social Security of its determination of disability and before the end of the 18-month COBRA continuation period.

Family members who are Qualified Beneficiaries and are not disabled during the first 60 days of COBRA coverage, but who elect COBRA coverage along with the disabled Qualified Beneficiary, may also extend their periods of coverage from 18 months to 29 months.

*Extension of Period of Coverage for Secondary Qualifying Events*

If your Eligible Dependent is covered under COBRA due to your termination of employment or reduction in hours and a second Qualifying Event occurs that is a death, divorce or legal separation, loss of dependent status, or entitlement to Medicare, that Eligible Dependent may receive up to an additional 18 months of coverage (for a total of 36 months). You or your Eligible Dependent must notify the Plan Administrator within 60 days of the second event. ***If you or your Eligible Dependent fail to notify the Plan Administrator within this 60-day period, the right to extend coverage for an additional 18 months will be lost***.

## 11.9 Termination of COBRA Coverage

The COBRA coverage period ends when the first of the following events occurs:

- The last day of the 18-, 29-, or 36-month maximum period (described above), as applicable;
- The Employer and its controlled group members, as defined by applicable law, cease to maintain any group health plan;
- The Qualified Beneficiary's COBRA premium is not paid in a timely manner (and note that COBRA coverage ends the last day of the month for which a timely payment is made);
- After electing COBRA coverage, the Qualified Beneficiary becomes covered under another group health plan, which does not contain an exclusion or limitation for any pre-existing condition that affects the Qualified Beneficiary or his or her Dependent after taking into account any creditable coverage of the Qualified Beneficiary;
- The Qualified Beneficiary becomes entitled to Medicare benefits after electing COBRA coverage; or
- If coverage was extended due to disability, a determination that the disabled Qualified Beneficiary is no longer disabled (such disabled Qualified Beneficiary must notify the Plan Administrator within 30 days of such determination, and COBRA coverage ends as of the later of (1) the month that begins more than 30 days after a final determination is made, or (2) the end of the original 18-month COBRA coverage period).

As soon as administratively practicable after a Qualified Beneficiary's COBRA coverage terminates, the Plan Administrator will provide such Qualified Beneficiary with notice of such termination and the effective date thereof.

## SECTION 12: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If you must provide health care coverage to a Dependent child under a QMCSO from a court, then you must request coverage for the child in writing within 31 days of the date of the order. Other court orders may be covered by this Plan as well. The Plan Administrator has sole and absolute discretion to determine whether any QMCSO is valid and binding upon the Plan and how such QMCSO applies to benefits under the Plan. If any eligible person has questions, they should contact the Plan Administrator.

## SECTION 13: NOTICE INFORMATION

### 13.1 General Notices

***Newborn and Mothers' Care***. Any Constituent Benefit Program that provides group health or medical coverage under this Plan generally does not, consistent with applicable 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 vaginal delivery, or less than 96 hours following a cesarean section. However, consistent with that same federal law, this Plan 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 48 hours (or 96 hours as applicable). In any case, this Plan does not, in accordance with 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 48 hours (or 96 hours).

***Women's Health and Cancer Rights Act of 1998 (WHCRA)***. As required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), notwithstanding anything herein to the contrary, any Constituent Benefit Program that provides group health or medical coverage under this Plan, provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

***Medicaid and Children's Health Insurance Program - ("CHIP")***. (Free or Low-Cost Health Coverage for Children and Families that may apply). For Eligible Employees who are Participants and are eligible for health coverage under any Constituent Benefit Program under the Plan, but are unable to afford the Employee portion of the total cost (sometimes referred to as the employee premium), some states have premium assistance programs that Participants may access to help pay for coverage. Certain states use funds from their Medicaid or CHIP programs to help people who are eligible for health coverage provided by employers, but need assistance in paying their health premiums.

For those Employees who are already enrolled in Medicaid or CHIP, or have Dependents so enrolled, they can contact the applicable State Medicaid or CHIP office to find out if premium assistance is available. If covered Dependents are not currently enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office, or dial 1-877- KIDS-NOW, or go to www.insurekidsnow.gov to find out how to apply for this premium assistance. If one qualifies, the program in the state where the individual resides will provide information as to whether it has a program that might help pay the premiums toward the Employee portion payable for coverage under the Plan. Once it is determined that the Eligible Employee or Dependent is eligible for premium assistance under Medicaid or CHIP, this Plan will permit such Eligible Employee or Dependent to enroll, as long as such persons are eligible, and not already enrolled. This is a special enrollment period for such individuals. Such individuals must request coverage within 60 days of being determined eligible for premium assistance.

***Additional Notices***. There are a number of related and additional notices that apply to the Plan, and in particular any Constituent Benefit Program that provides for group health or medical coverage. Such notices are contained in the Plan's Notices and Information Packet. These notices are incorporated by reference herein. If you do not have access to the Packet that was distributed, see the Plan Administrator, or Human Resources representative for a copy.

## SECTION 14: GENERAL COMPLIANCE AND OTHER INFORMATION

### 14.1 No Vesting

***Benefits Are Not Subject to Vesting and Are Not Vested***. As stated above, the Plan may be amended or terminated at any time. Any amendment may at the determination of the Employer, change, reduce, eliminate or otherwise affect benefits provided for under this Plan and no Eligible Spouse, Dependent or beneficiary has any vested right, whatsoever, to benefits under the Plan or any Constituent Benefit Program.

### 14.2 HIPAA Rules, Policies and Procedures

***Health Insurance Portability and Accountability Act.***

It is intended that this Plan comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009, Title XIII of division A and Title IV of division B of the American Recovery and Reinvestment Act ("ARRA"), and the regulations issued under HIPAA, HITECH and ARRA (together we refer to HIPAA, HITECH and ARRA as "HIPAA"). Any Rules and/or Policy adopted by the Employer that addresses HIPAA are automatically incorporated in this Plan by reference and become part of the Plan.

HIPAA requires certain entities called "Covered Entities," which include the Plan, to safeguard and protect the privacy of individuals' health information, to limit how individuals' health information may be used and disclosed, to grant certain rights to individuals with respect to their health information, and to maintain certain administrative processes that address these rules.

The Plan and Plan Administrator will not generally have regular access to any Protected Health Information ("PHI"), as that term is described under HIPAA. In the event that any PHI is provided to the Plan Administrator, it will be disclosed or obtained with the required consent in order to assist you in your access to benefits, or some other function under the Plan. Any such information obtained will be protected from dissemination and will be used only for purposes under the Plan. All HIPAA protections within the Constituent Benefit Programs that are health plans shall apply and the insurance providers in such Constituent Benefit Programs will provide to all Eligible Employees, Spouses and Dependents the required Notices and Information.

### 14.3 USERRA Leave

***Leave Under the Uniformed Services Employment and Re-employment Rights Act ("USERRA").*** If you leave your job to perform military service, you have the right to elect to continue any existing group health plan coverage for up to 24 months while in the military. Coverage is at your cost and works like the COBRA coverage stated above.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

### 14.4 FMLA Leave

***Family and Medical Leave Act ("FMLA").*** The FMLA entitles eligible employees to take up to 12 weeks of unpaid, job protected leave each year for specified family and medical reasons. For a medical leave, any period for which you are paid short-term disability or workers' compensation benefits will count against any period of available FMLA leave. See your Human Resources Department for additional information on the FMLA. The Employer's leave policies apply.

### 14.5 No Employment Rights

***No Right of Employment.*** This Plan does not confer upon anyone a right or contract of employment in any way and is not to be construed as constituting a contract or other arrangement between any employee and the Company to the effect that an employee is, or will be employed for any specific period of time, or otherwise.

### 14.6 Fraud or Concealment

***Fraud or Concealment.*** By participating in this Plan and any of the Constituent Benefit Programs, you agree to provide accurate and truthful information concerning any of your benefits or any subject matter for which you need to provide information in connection with your participation in the Plan. This applies to your Spouse, Dependents and beneficiaries as well. In the event of any fraud, or concealment or any untruthful information provided by any person related to any benefit under this Plan, any of the rights and remedies under law and the applicable Constituent Benefit Programs shall apply and the Plan Administrator and the Employer may undertake any act or remedy available to it in this regard.

### 14.7 Compromise of Claims

***Compromise of Claims.*** The Employer and any of the insurers of any Constituent Benefit Program may compromise any claim filed under the Plan, in accordance with the terms of the Constituent Benefit Programs, or otherwise, as long as they satisfy obligations to the Eligible Employees and their Eligible Spouses, Dependents and beneficiaries.

### 14.8 References and Inconsistencies

***References and Inconsistencies.*** Any references to the Plan include each of the Constituent Benefit Programs, unless the context specifically suggests otherwise. In the event that any term, provision or statement in a Constituent Benefit Program conflicts with or creates ambiguity with this Plan Document and Summary Plan Description, this document shall control and the Plan Administrator has full and complete discretionary authority to interpret the terms, determine facts and reconcile any inconsistency, or determine the meaning of any provision.

### 14.9 Applicable Law

***Applicable Law.*** This Plan is subject to ERISA, which pre-empts state law. To the extent that federal law does not apply for any reason, any claim brought with respect to the Plan must be brought in the courts where the Plan Sponsor is headquartered.

## SECTION 15: STATEMENT OF ERISA RIGHTS

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

***Receive Information About Your Plan and Benefits***

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

***Continue Group Health Plan Coverage***

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

***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 Participant s and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

***Enforce Your Rights***

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

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

***Assistance with Your Questions***

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

## SECTION 16: PLAN INTERPRETATION

The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe any and all terms of the Plan, including, but not limited to, any disputed or doubtful terms, to the extent that this right is not specifically reserved to any insurer or other administrator, or the Claims Administrator under any Constituent Benefit Program. The Plan Administrator also has the power and discretion to determine all questions of fact and law arising in connection with the administration, interpretation and application of the Plan, unless such right is specifically reserved to any insurer or other administrator, or Claims Administrator under a Constituent Benefit Programs. Any and all determinations by the Plan Administrator with respect to any aspect of the Plan, not otherwise reserved to the insurer, administrator or Claims Administrator under the Constituent Benefit Programs, is and will be conclusive and binding on all persons with respect to this Plan.

## SECTION 17: ADOPTION

This Plan is hereby adopted by the Employer, effective as of the date indicated herein, as a formal wrap plan document for this Plan, and also the Summary Plan Description for the Plan, incorporating by reference the applicable Constituent Benefit Programs in Exhibit A.

This Plan is hereby adopted and approved by the Employer and is effective as stated herein.

**Cleveland Guardians Baseball Co., LLC**

By: _____

Print Name: _____

Title: _____

© 2026 EZ ERISA LLC

*This Wrap Document and Summary Plan Description for use by the Employer subject to a license by EZ ERISA, LLC and this form and its related processes are protected by Trademark and Copyright protection.*

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Option #1 (Closed)<br>$400/$800 In Network Deductible |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Medical |
| Grandfathered Status for Group Health Plan | Yes |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | All Full - Time Employees regularly scheduled to work (30) hours or more |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |
| Does this Plan Have a Health Savings Account ("HSA") Option? | No |
| Does this Plan include a Wellness Component? | Yes |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Option #2<br>$600/$1200 In Network Deductible |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Medical |
| Grandfathered Status for Group Health Plan | No |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | All Full - Time Employees regularly scheduled to work (30) hours or more |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |
| Does this Plan Have a Health Savings Account ("HSA") Option? | No |
| Does this Plan include a Wellness Component? | Yes |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Plan B<br>$1000/$2000 In Network Deductible |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Medical |
| Grandfathered Status for Group Health Plan | No |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | Employees regularly scheduled to work thirty (30) hours or more per week |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |
| Does this Plan Have a Health Savings Account ("HSA") Option? | No |
| Does this Plan include a Wellness Component? | Yes |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | 3400 HSA<br>$3400/$6800 In Network Deductible |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Medical |
| Grandfathered Status for Group Health Plan | No |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | Employees regularly scheduled to work thirty (30) hours or more per week |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |
| Does this Plan Have a Health Savings Account ("HSA") Option? | Yes |
| Does this Plan include a Wellness Component? | Yes |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Dental Plan PPO |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Dental |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | Employees regularly scheduled to work thirty (30) hours or more per week |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Vision Plan PPO |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Vision |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Self-Insured |
| Eligible Employees: | Employees regularly scheduled to work thirty (30) hours or more per week |
| Eligible Entry: | First day of active work |
| Who Pays for the Coverage: | Combination of Employer and Employee contributions |
| Any Restrictions or other Rule on Spouse Participation? | None |
| Is Spousal Coverage Subject to a Limitation Secondary Coverage Only? | N/A |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Basic Life Insurance Plan |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Life Insurance |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Insured |
| Class: | Class 1 |
| Employees Eligible For Class: | All Full-Time Employees |
| Eligibility Requirements For Class: | Employees regularly scheduled to work 40 hours or more per week |
| Eligible Entry Dates For Class: | First day of active work |
| Who Pays for the Coverage: | Paid 100% by the Employer |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Voluntary Life Insurance Plan |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Life Insurance |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Insured |
| Class: | Class 1 |
| Employees Eligible For Class: | All Full-Time Employees |
| Eligibility Requirements For Class: | Employees regularly scheduled to work 40 hours or more per week |
| Eligible Entry Dates For Class: | First day of active work |
| Who Pays for the Coverage: | 100% Voluntary, Paid by the Employee Only |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Basic AD&D Coverage |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Accidental Death and Dismemberment |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Insured |
| Class: | Class 1 |
| Employees Eligible For Class: | All Full-Time Employees |
| Eligibility Requirements For Class: | Employees regularly scheduled to work 40 hours or more per week |
| Eligible Entry Dates For Class: | First day of active work |
| Who Pays for the Coverage: | Paid 100% by the Employer |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Voluntary AD&D Coverage |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Accidental Death and Dismemberment |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Insured |
| Class: | Class 1 |
| Employees Eligible For Class: | All Full-Time Employees |
| Eligibility Requirements For Class: | Employees regularly scheduled to work 40 hours or more per week |
| Eligible Entry Dates For Class: | First day of active work |
| Who Pays for the Coverage: | 100% Voluntary, Paid by the Employee Only |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan or Program Insurer: | Medical Mutual of Ohio |
| Description of the Plan or Program: | Long Term Disability Plan |
| Policy or Group Number: | 313166 |
| Type(s) of Benefit(s) Provided: | Long Term Disability |
| Contract Year Begins: | January 1st |
| Insured or Self-Insured: | Insured |
| Class: | Class 1 |
| Employees Eligible For Class: | All Full-Time Employees |
| Eligibility Requirements For Class: | Employees regularly scheduled to work 40 hours or more per week |
| Eligible Entry Dates For Class: | First day of active work |
| Who Pays for the Coverage: | Paid 100% by the Employer |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan: | Cleveland Guardians Baseball Co., LLC Cafeteria Plan |
| Type(s) of Benefit(s) Provided: | Cafeteria Plan |
| Eligible Employees: | Employees who become eligible for any Constituent Benefit Program that requires an Employee Contribution |
| Eligible Entry Dates: | When the Employee becomes eligible for any Constituent Benefit Program that requires an Employee Contribution |
| Does the Cafeteria Plan Offer A Flexible Spending Account ("FSA")? | Yes FSA Limit is stated in Cafeteria Plan |
| Does the Cafeteria Plan Offer A Dependent Care Assistance Program ("DCAP")? | Yes DCAP Limit is stated in the Cafeteria Plan |
| Does the Cafeteria Plan Offer Voluntary Benefits to be paid on a pre-tax basis? | Yes. Voluntary benefit limit is stated in the Cafeteria Plan |
| Does the Cafeteria Plan Offer A Health Savings Account ("HSA")? | Yes. HSA Limits are stated in the Cafeteria Plan Document |

**Exhibit A - Constituent Benefit Programs**

| | |
|---|---|
| Plan: | Cleveland Guardians Baseball Co., LLC Employee Assistance Plan ("EAP") |
| Contract Number (If Any): | N/A |
| Type(s) of Benefit(s) Provided: | Employee Assistance Plan |
| Insured or Self-Insured: | Employer Funded |
| Eligible Employees and Entry Date | Pursuant to terms of existing EAP arrangement |

## Exhibit B

The following are Participating Employers in the Plan:

No other companies participate