Your Thryv Health & Welfare Benefits - General Administration

Active Employees

July 2019

Contents

Introduction

Overview

Benefit coverages are provided through The Thryv Plan for Employee Group Insurance (the "Plan"). As long as you meet the Plan's eligibility requirements, you and your eligible dependents may participate in the benefit coverages options under the Plan. This is one part of a multi-part document that, when viewed together with the other parts, make up the Summary Plan Description (SPD) for the Plan.

In this part of the SPD you will find general administration and contact information, claims and appeal procedures, continuation coverage under **COBRA**, and your rights under **ERISA**. Other parts of the SPD describe who is eligible to be covered under the Plan and provide details about the benefit coverages available under the Plan. Key terms are bolded throughout and defined in the Glossary part of the SPD.

Your Duties and Responsibilities

Operating a successful benefits program is a cooperative effort. To receive benefits under the Plan, all participants and beneficiaries must cooperate with the reasonable requests of the **Company, Plan Administrator,** and **claims administrators** or their designated agents, in enforcing the Plan's terms. Your responsibilities include items such as:

- Promptly providing all of the information that the **Plan Administrator** may request.
- Notifying the **Plan Administrator** immediately if you feel that any report related to your benefits is inaccurate.
- Making sure that the **Company** has your current address.
- Keeping your beneficiary designation up to date.
- Keeping your enrolled dependent information up to date at the Thryv Benefits Center.

Failing to notify the **Plan Administrator** of benefit-affecting events and/or changes to your information may result in a delay in payment or loss or reduction of benefits under the Plan. You are financially liable for claims **incurred** by any ineligible dependent and you may be required to reimburse the **Company** for any associated costs.

The Use of Social Security Numbers

You will be asked to provide your Social Security number for Plan purposes. The **Company** and the **claims administrators** have the right to use your Social Security number for the purpose of administering the Plan, including paying benefits under the Plan and for tax-reporting purposes.

All covered dependents must provide a valid Social Security number or, if the dependent is unable to obtain a valid Social Security number, he or she must provide an Individual Taxpayer Identification Number (ITIN). Failure to provide one of these numbers in a timely manner will result in ineligibility for coverage under the Plan.

Note: While some state laws do restrict the use of Social Security numbers, these laws generally are preempted by ERISA for the purpose of administering your benefits and coverages.

Amendment and Termination

The information provided in the SPD describes the Plan generally as in effect on January 1, 2019. The **Company** and the **Plan Administrator** reserve the right to amend, modify, suspend, revoke, or terminate the Plan, in whole or in part at any time, including, but not limited to, **Company** and/or participant contributions, for any reason, at their discretion, and with or without advance notice, except to the extent limited by an applicable collective bargaining agreement. If a Plan or benefit coverage is terminated in whole or part, you will not have any further rights other than payment of expenses you had **incurred** before the Plan or benefit coverage was terminated. The SPD may be supplemented from time to time to reflect material amendments or modifications to the Plan.

Other Important Information

In summarizing the terms of the Plan in the SPD, every attempt has been made to make the SPD as detailed and accurate as possible. However, Plan documents and insurance/administrator policies/contracts/requirement documents (collectively “Plan Materials”) govern the Plan. To the extent that there is a conflict between the SPD and the Plan Materials, the Plan Materials shall govern.

Your participation in the Plan and its benefit coverages does not ensure you of continued (or renewed) employment with the **Company**.

Plan Information and Questions

Primary Resources

The Thryv Benefits Center Website

This online resource is your primary point of access to view personalized benefit information, initially enroll in coverages, enroll during Annual Enrollment periods, retrieve detailed benefit information, link to various online tools, make a mid-year change to your coverages, and keep your beneficiary information current.

You can access the Thryv Benefits Center website remotely, 24 hours a day, seven days a week directly at: https://MyThryvBenefits.com or from the HR section of the **Company**'s intranet.

The Thryv Benefits Center

The Thryv Benefits Center is available to help you enroll, make changes, or ask questions. Customer Service Representatives (CSRs) staff the center, are trained in and knowledgeable about the Plan's eligibility requirements and your enrollment status, and can help answer your questions. CSRs are available between 8:00 a.m. and 5:00 p.m. Central time Monday through Friday (except **Company**-wide holidays). You will be asked to validate your identity when you call.

Please Note: **COBRA** is administered through a separate division of the Thryv Benefits Center. For answers to **COBRA**-related questions, call 866-847-1300 Opt. 3, Opt. 1.

Assistance With Benefit Coverages

Each of the benefit coverages under the Plan are administered by a responsible entity. The chart below provides specific information for each entity on how to obtain information or assistance, and the procedures for filing claims and appeals. When you have questions about a particular benefit coverage or are filing a claim, you should work directly with the responsible entity.

Responsible Entity	General Coverage and Information Contact	Claims and Appeals Contact
Eligibility, Enrollment and COBRA		
Thryv Benefits Center	Thryv Benefits Center Call 1-866-847-1300, option 3, then option 1 https://MyThryvBenefits.com **Hours of Operation:** Monday through Friday, 8 a.m. to 5 p.m. (CT)	**Level I Claim:** Thryv Benefits Center C/O Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-14071-866-847-1300, option 3, then option 1 **Level II Appeal:** *Thryv Health and Welfare Claim Team* C/O Claims and Appeals Management P.O. Box 1407

Responsible Entity	General Coverage and Information Contact	Claims and Appeals Contact
		Lincolnshire, IL 60069-1407 1-866-847-1300, option 3, then option 1 **Level III Appeal:** Plan Administrator, Thryv Employee Benefits and Asset Management Committee C/O Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 1-866-847-1300, option 3, then option 1
Medical Claims & Benefits		
CIGNA	CIGNA P.O. Box 5200 Scranton, PA 18505-5200 1-800-CIGNA (1-800-244-6224) www.myCIGNA.com **Hours of Operation:** 24 Hours a Day, 7 Days a Week	**For All Claims and Levels of Appeal:** CIGNA P.O. Box 5200 Scranton, PA 18505-5200 1-800-CIGNA (1-800-244-6224) www.myCIGNA.com
Wellness Program		
Virgin Pulse	Virgin Pulse 75 Fountain St Providence, RI 02902 1-888-671-9395 By email: support@virginpulse.com **Hours of Operation:** 7:00 a.m. – 8:00 p.m. (CT) M-F Member Log In: https://www.virginpulse.com/	**For Claims and Level II Appeals:** Virgin Pulse, Attn: Member Services 75 Fountain St Providence, RI 02902 1-888-671-9395 By email: support@virginpulse.com **For Level III Appeals:** Plan Administrator, Thryv Employee Benefits and Asset Management Committee C/O Virgin Pulse Attn: Member Services 75 Fountain St Providence, RI 02902 1-888-671-9395 By email: support@virginpulse.com
Prescription Drug Claims & Benefits		
CVS/Caremark (CIGNA medical plans only)	CVS/Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 1-888-766-5513 www.caremark.com	**For All Claims and Levels of Appeal:** CVS/Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196

Responsible Entity	General Coverage and Information Contact	Claims and Appeals Contact
	Hours of Operation: 24 Hours a Day, 7 Days a Week	1-888-766-5513 www.caremark.com
Employee Assistance Plan		
ComPsych	ComPsych PO Box 8379 Chicago, IL 60680-8379 1-800-858-6714; (TDD 1-800-697-0353) www.guidanceresources.com (Web ID:MI4370T) **Hours of Operation:** 24 Hours a Day, 7 Days a Week	**For All Claims and Levels of Appeal:** ComPsych PO Box 8379 Chicago, IL 60680-8379 1-800-858-6714 www.guidanceresources.com
Dental Claims & Benefits		
MetLife	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998 1-800-942-0854 www.metlife.com/dental **Hours of Operation:** M-F, 7 a.m. to 10 p.m. (CT)	**For All Claims and Levels of Appeal:** MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998 1-800-942-0854 www.metlife.com/dental
Vision Claims & Benefits		
Superior Vision	Superior Vision Claims Administration P.O. Box 967 Rancho Cordova, CA 95741 1-800-507-3800 TDD (hearing impaired): 1-916-852-2382 www.superiorvision.com **Hours of Operation:** M-F 7 a.m. – 8 p.m. CT Sat 10 a.m. – 3 p.m. CT	**For All Claims and Levels of Appeal:** Superior Vision Claims Administration Office Superior Vision Services, Inc. P.O. Box 967 Rancho Cordova, CA 95741 1-800-507-3800 www.superiorvision.com

Responsible Entity	General Coverage and Information Contact	Claims and Appeals Contact
Flexible Spending Account Claims & Benefits		
Your Spending Account	Your Spending Account CLAIMS ADMINISTRATOR P.O. Box 785040 Orlando, FL 32878-5040 1-866-847-1300 Option 3, then Option 1 https://MyThryvBenefits.com **Hours of Operation:** M-F 8 a.m. – 5:00 p.m. CT	**For All Claims and Levels of Appeal:** Your Spending Account CLAIMS ADMINISTRATOR P.O. Box 64030 The Woodlands, TX 77387-4030 1-866-847-1300 Option 3, then Option 1 https://MyThryvBenefits.com
Life and AD&D Claims & Benefits		
MetLife	MetLife P.O. Box 330 Warwick, RI 02887-0330 1-800-438-6388 www.metlife.com/mybenefits **Hours of Operation:** 24 Hours a Day, 7 Days a Week	**For All Claims and Levels of Appeal:** MetLife P.O. Box 330 Warwick, RI 02887-0330 1-800-438-6388 www.metlife.com/mybenefits
Business Travel Accident Claims & Benefits		
AIG – Travel Guard Assistance	AIG Claims Dept. P.O. Box 25987 Shawnee Mission, KS 66225-5897 www.aigbenefits.com/travelassist 1-877-244-6871 Inside US 1-715-346-0859 Outside US **Hours of Operation:** **24 Hours a Day, 7 Days a Week**	**For All Claims and Levels of Appeal:** AIG Accident & Health Claims Division P.O. Box 25987 Shawnee Mission, KS 66225 **www.aigbenefits.com/travelassist**
Disability Claims & Benefits		
Prudential	Prudential Disability Management Services P.O. Box 13480 Philadelphia, PA 19176 1-877-367-7781 www.prudential.com/mybenefits **Hours of Operation:** 24 Hours a Day, 7 Days a Week	**For Claims:** The Prudential Insurance Company of America Disability Management Services P.O. Box 13480 Philadelphia, PA 19176 1-877-367-7781 www.prudential.com/mybenefits

Responsible Entity	General Coverage and Information Contact	Claims and Appeals Contact
		For Appeals: *Thryv Health and Welfare Claim Team* c/o The Prudential Insurance Company of America Disability Management Services P.O. Box 13480 Philadelphia, PA 19176

Claims and Appeals Procedures

Overview

A disagreement regarding your eligibility, coverage, or right to receive a benefit or reimbursement may arise. If this happens, this section outlines the formal procedures in place should you need to file a claim or an appeal. See the chart in the "Assistance With Benefit Coverages" section for information about who to contact should you need to file a claim or appeal.

In the event that you wish to dispute an action taken in regard to your benefits under the Plan:

- You must first file a Level I claim challenging the adverse determination with the responsible entity that made the determination.
- If you're not satisfied with the decision made on your Level I claim, you may then file up to two appeals*. The decision of the second appeal* is final and no other internal appeals are available. You then have a right to bring a civil action.
- Your claim or appeal must be filed within:
    - The specified time periods outlined below; or
    - the applicable **claims administrator's** time period if more generous.

* Some **claims administrators** under the Plan utilize only one level of appeal. If your claim and first appeal are denied by a **claims administrator** which only utilizes one level of appeal, the decision of the first appeal is final and you then have a right to bring a civil action thereafter.

Eligibility or Benefit Claims and Appeals

A claim or appeal must be directed to the entity that is responsible for the benefit being disputed, as follows:

- Eligibility and Enrollment: A claim or appeal pertaining to participation or enrollment in the Plan or a coverage option or a mid-year change to an election to participate, must be filed through the Thryv Benefits Center.

- Benefit Payment and Reimbursement: A claim or appeal pertaining to a specific benefit payment or reimbursement under any of the coverages under the Plan must be filed with the appropriate **claims administrator**.

The Four Categories of Claims and Appeals

All claims and appeals fall in one of four categories that are based on how much time is needed to conduct the review and how quickly a decision must be made. These categories also drive the process of how to submit claims and appeals, and they define the timing that is involved to review such claims and appeals. The four categories are:

- Pre-Service: A claim or appeal on a benefit that requires **prior authorization** by the Plan.

- Post-Service: A claim or appeal on a reimbursement for services already received or a payment for benefits (e.g., life insurance payments). This is the most common type of claim or appeal.

- **Urgent Care**: A claim or appeal for medical care or treatment that, if the regular review and decision were used, it could take an extended period and delay treatment which:
    - Could seriously jeopardize the health of the patient or his or her ability to regain maximum function; or
    - In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not be managed without the care or treatment that is the subject of the claim or appeal.

- Concurrent Care: A claim or appeal for ongoing treatments over a period of time or a number of treatments. For example, you may receive authorization to receive seven treatments from a therapist. If, during the treatment, the therapist suggests you receive 10 treatments, your claim is considered a concurrent care claim or appeal. Some concurrent care claims or appeals are also **urgent care** claims or appeals.

How to File a Claim (Level I)

Regardless of the type or category of claim, you have the opportunity to challenge an adverse determination. This is your first level of review and must precede an appeal. Be sure to include a description of the benefits for which you are applying, the reason(s) for your request, and any relevant supporting documentation, for example receipts and explanation of benefits ("EOB") statements.

- Claims Pertaining to Eligibility and Enrollment: To file a claim pertaining to eligibility or enrollment, request the appropriate form from the Thryv Benefits Center. You (or your authorized representative) must return the appropriate form to the Thryv Benefits Center at the address noted on the form. *If your claim is for **urgent care** as defined in this section, state that you are filing an **urgent care** claim when you call the Thryv Benefits Center.*

- Claims Pertaining to Plan Benefits: To file a claim pertaining to a benefit determination, request the appropriate form from the **claims administrator**, or download the appropriate form from the **claims administrator's** website. You (or your authorized representative) must return the appropriate form to the **claims administrator** at the address noted on the form. *If your claim is for **urgent care** as defined within this section, contact the **claims administrator** and state that you are filing an **urgent care** claim.*

Once the Thryv Benefits Center or **claims administrator** receives your completed claim and conducts its review, you receive notice of the decision within the following time periods (or as required by law).

- Pre-Service: Within 15 days. This period may be extended for an additional 15 days (you are notified of the extension within the initial 15-day period).

- Post-Service: Within 30 days. This period may be extended for an additional 15 days (you are notified of the extension within the initial 30-day period).

- **Urgent Care**: Within 72 hours.

- Concurrent Care: Within a time period that is sufficiently in advance of the reduction or termination of coverage so that you can appeal and obtain a response before coverage is actually reduced or terminated. If concurrent care is of an urgent nature, the decision is provided within 24 hours (provided you submit a claim at least 24 hours in advance of the reduction or termination of coverage); otherwise, within 72 hours.

If you fail to provide sufficient information, the Thryv Benefits Center or **claims administrator** may request the additional information within the following time periods:

- Pre-Service: Within 15 days. You then have 45 days in which to provide the additional information. You are notified of the decision within the time period remaining for the initial claim.

- Post-Service: Within 30 days. You then have 45 days in which to provide the additional information. You are notified of the decision within the time period remaining for the initial claim.

- **Urgent Care**: Within 72 hours. Your then have 48 hours in which to provide the additional information. You are notified of the decision within 48 hours.

- Concurrent Care: Not applicable.

If you do not provide the additional information within the time periods noted above, the claim is decided based on the original information provided.

Unless otherwise provided in this SPD or the Plan Materials, a claim must be submitted within 180 days after the occurrence of the event on which the claim is based.

Notification for Claims

If your eligibility and enrollment or benefit claim is *approved*, you are notified by phone or in writing (for example, for medical benefit claims, you generally receive an EOB as your notification).

If your eligibility and enrollment or benefit claim is *denied* (in whole or in part), you are notified by phone or in writing (except for **urgent care**, in which case you receive notification by phone). Notification includes all of the following:

- The specific reason(s) for the denial.
- References to the specific Plan provision(s) upon which the denial was based.
- Any additional material or information necessary to process the claim and an explanation of why such material or information is necessary.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures (in the case of an **urgent care** claim, a description of the expedited review process).

- Any internal procedures or clinical information upon which the denial was based (or a statement that this information will be provided free of charge, upon request).
- Contact information for the Commissioner of Insurance.
- For **urgent care** claims, a telephone notification is followed up within three days with a written denial notice. The denial notice also explains the expedited review process.

How to File an Appeal

Before you can bring any action at law or in equity to recover eligibility or benefits, you must exhaust the appeals process with the appropriate claims fiduciary. The **Plan Administrator** has delegated fiduciary authority to the applicable **claims administrator** to provide claim processing, claim investigation, plan interpretation, and daily administration for all benefit coverages except the self-insured short-term disability. Depending on whether you have an eligibility/enrollment or a benefit appeal, the claims fiduciary is as shown in the chart below.

Type of Appeal	Claims Fiduciary
Eligibility and Enrollment	**First Appeal (Level II):** Thryv Health and Welfare Claim Team **Second Appeal (Level III):** Plan Administrator
Benefit Payment and Reimbursement	Claims Administrator Both Level II and Level III Appeals (except for short-term disability) are sent to the appropriate **claims administrator***. Level II and Level III Appeals for self-insured short-term disability benefits are sent to the **Plan Administrator** via the **claims administrator**.

* Some **claims administrators** under the Plan utilize only one level of appeal. If your first appeal is denied by a **claims administrator** which only utilizes one level of appeal, the decision of the first appeal is final and you then have a right to bring a civil action thereafter.

The claims fiduciary provides final determination regarding your appeals. The claims fiduciary is authorized to provide this determination and interpret the terms of the Plan at its sole discretion. The claims fiduciary's decisions regarding appeals are final and binding on all parties.

First Appeal (Level II)

If your Level I claim is denied, you may file a Level II appeal. Appeals must be received by the applicable administrator within 180 days of the date your claim was denied. You can request access to all documentation that relates to your appeal.

The individual/committee (and any medical experts) that reviews your appeal is independent from those who reviewed your initial benefit claim. In addition, if your appeal involves a medical judgment, the **claims administrator** consults with a health care professional with the appropriate and relevant experience. You are entitled to know the identity of such experts upon request.

The procedures for filing a Level II Appeal are as follows:

- Eligibility and Enrollment Appeals: If your eligibility or enrollment claim has been denied and you want to file an appeal, you must submit your appeal in writing to the Thryv Health

and Welfare Claim Team. You (or your authorized representative) must send your written appeal to the address included on your claim denial notice. *If your appeal is for **urgent care** as defined in this section, you can verbally file your appeal with the Thryv Health and Welfare Claim Team.* The Thryv Health and Welfare Claim Team gives you instructions on how to file an appeal for an **urgent care** claim at the time the claim is denied. Be sure to indicate that you are filing an **urgent care** appeal.

- Benefit Appeals: If your benefit claim has been denied and you want to file an appeal, you must submit your appeal in writing to the **claims administrator**. You (or your authorized representative) must send your written appeal to the address included on your claim denial notice. Be sure to include a copy of your claim denial notice, the reason(s) for your appeal, and any relevant supporting documentation (including receipts and EOBs). *If your appeal is for **urgent care** as defined in this section, you can verbally file your appeal with the **claims administrator**.* The **claims administrator** gives you instructions on how to file an appeal for an **urgent care** claim at the time the claim is denied. Be sure to indicate that you are filing an **urgent care** appeal.

Once the Thryv Health and Welfare Claim Team or **claims administrator** receives your appeal and, based on the category of your appeal, you will receive notice of its decision within the following time periods (or as required by law):

- Pre-Service: Within 15 days of receipt of your appeal.
- Post-Service: Within 30 days of receipt of your appeal.
- **Urgent Care**: Within 72 hours of receipt of your appeal.
- Concurrent Care: Before a reduction or termination of coverage. If concurrent care is of an urgent nature, the decision is provided within 72 hours.

If additional time is needed to review your appeal, you will be notified by phone or in writing.

Second Appeal (Level III), if available

If your Level II Appeal has been denied, you may appeal to the **Plan Administrator** or **claims administrator** a second and final time, provided a Level III Appeal is available. If a Level III Appeal is not available, then the Level II Appeal decision is final. A Level III Appeal must be received within 180 days of the date your first appeal was denied.

If applicable, the **claims administrator** provides you with an independent medical review, upon request, in conjunction with this second and final appeal (as applicable). The individual/committee (and any medical experts) that reviews your Level III Appeal is independent from those who reviewed your Level II Appeal. In addition, if your appeal involves a medical judgment, the **claims administrator** consults with a health care professional with the appropriate and relevant experience. You are entitled to know the identity of such experts upon request. The procedures for filing a Level III Appeal are as follows:

- Eligibility and Enrollment Appeals: You must submit your Level III Appeal in writing to the **Plan Administrator**. You (or your authorized representative) must send your written appeal to the address included on your Level II Appeal denial notice. Be sure to include a copy of your Level II Appeal denial notice, the reason(s) for your appeal, and any relevant supporting documentation. *If your appeal is for **urgent care** as defined in this section, you can verbally file your appeal with the **Plan Administrator**.*

- Benefit Appeals: You must submit your Level III Appeal in writing to the claims **administrator**. You (or your authorized representative) must send your written appeal to the address included on your Level II Appeal denial notice. Be sure to include a copy of your Level II Appeal denial notice, the reason(s) for your appeal, and any relevant supporting documentation (including receipts and EOBs). *If your appeal is for **urgent care** as defined in this section, you can verbally file your appeal with the **claims administrator**.*

Once the **Plan Administrator** or **claims administrator** receives your Level III Appeal and, based on the category of your appeal, you will receive notice of its decision within the following time periods (or as required by law):

- Pre-Service: Within 15 days of receipt of your second and final appeal.
- Post-Service: Within 30 days of receipt of your second and final appeal.
- **Urgent Care**: Within 72 hours of receipt of your second and final appeal.
- Concurrent Care: Before a reduction or termination of coverage. If concurrent care is of an urgent nature, the decision is provided within 72 hours.

If your Level III Appeal is denied, the **Plan Administrator** or **claims administrator** does not review your matter again unless new facts are presented. You then have a right to bring a civil action.

Notification for Level II and Level III Appeals

If your eligibility and enrollment or benefit appeal is *approved*, you are notified in writing.

If your eligibility and enrollment or benefit appeal is *denied* (in whole or in part), you will be notified in writing (except for **urgent care**, in which case you receive the notification by phone). The denial notification includes all of the following.

- The specific reason(s) for the denial.
- References to the specific Plan provision(s) upon which the denial was based.
- A statement regarding the relevant documents, records, and other information to which you are entitled, upon request and free of charge, including those that:
  - Were relied upon in making the determination;
  - Were submitted, considered, or generated in the course of making the determination;
  - Demonstrate compliance with the Plan's administrative processes or safeguards; or
  - Constitute a statement of the Plan's policy or guideline with regard to the benefit for your diagnosis (whether relied upon or not).
- An explanation of the voluntary appeal procedures (if any) and your right to bring a civil action under Section 502(a) of **ERISA**.

- Any internal procedures or clinical information upon which the denial was based (or a statement that this information is provided free of charge, upon request).
- 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.”

Civil Actions Under ERISA

Because you are enrolled in a Plan that is subject to **ERISA**, if you are not satisfied with the outcome of the appeals process you have the right to file a civil action under Section 502(a) of **ERISA**. However, you cannot bring legal action to recover any benefit, eligibility, or enrollment-related appeal under the Plan if you do not file valid appeals and seek timely review of the denial of your appeals. In other words, you must fully exhaust the foregoing administrative appeal process before you can bring a legal action.

Unless otherwise provided in this SPD or the Plan Materials, an individual whose claim has been denied, in whole or in part, on the final level of appeal (“a final administrative denial”) may not file a civil action with respect to the denied claim after the date that is 180 days after the claimant is notified of the final administrative denial. Unless otherwise provided in this SPD or the Plan, any action or claim brought pursuant to the Plan must be brought in a venue located in the state of Texas.

You also may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or applicable state insurance regulatory agency.

Standard of Judicial Review of Claim Fiduciary Decisions

The foregoing claim fiduciaries have full and absolute discretion in the exercise of each and every aspect of their authority under the Plan, including, without limitation, the authority to determine any person’s right to continuation coverage under the Plan, as applicable. Notwithstanding any provision of law or any explicit or implicit provision of this document or any action taken, or ruling or decision made, by the foregoing claim fiduciaries in the exercise of any of their powers and authorities under the Plan, all actions, rulings, and decisions shall be final and conclusive as to all parties other than the **Company** and the **Plan Administrator**, including, without limitation, all employees and dependents, regardless of whether the foregoing claim fiduciaries or one or more of their members may have an actual or potential conflict of interest with respect to the subject matter of the action, ruling, or decision. No final action, ruling, or decision of the foregoing claim fiduciaries shall be subject to de novo review in any judicial proceeding; and no final action, ruling, or decision of one of the foregoing claim fiduciaries may be set aside unless it is held to have been arbitrary and capricious by a final judgment of a court having jurisdiction with respect to the issue.

Administrative Information

Details Regarding the Administration of the Plan

The Plan is governed by **ERISA**. Here is some important information you may need relative to the Plan.

Type of coverage	Plan Type	Claims Administrator/ Insurer	Type of Insurance
Medical			
High Deductible Health Plan (HDHP), including Health Savings Account (HSA)	Health	CIGNA	Self-insured
Low Deductible Health Plan (LDHP)	Health	CIGNA	Self-insured
Out of Area Plan	Health	CIGNA	Self-insured
Wellness Program			
All Employees	Welfare	Virgin Pulse	Not applicable
Prescription Drug			
All Medical Coverage Options	Health	Caremark/CVS	Self-insured
Employee Assistance Plan (EAP)			
EAP	Welfare	ComPsych	not applicable
Dental			
Core Dental PPO	Health	MetLife	Self-insured
Enhanced Dental PPO	Health	MetLife	Self-insured
Vision			
Vision Plan	Health	Superior Vision	Fully-insured
Flexible Spending Accounts			
Health Care FSA	Health	YSA	Self-insured
Dependent Care FSA	Welfare	YSA	Self-insured
Life and Accidental Death and Dismemberment			
Basic Life	Welfare	MetLife	Fully-insured

Type of coverage	Plan Type	Claims Administrator/ Insurer	Type of Insurance
Supplemental Life (Employee, spouse, and Child(ren))	Welfare	MetLife	Fully-insured
Basic AD&D	Welfare	MetLife	Fully-insured
Supplemental AD&D	Welfare	MetLife	Fully-insured
Disability			
Short Term Disability	Welfare	Prudential	Self-insured (NY and NJ state disability plans are fully-insured)
Long Term Disability	Welfare	Prudential	Fully-insured
Business Travel Accident			
Business Travel and Accident	Welfare	AIG	Fully-insured

Plan Name & Plan Number

The formal name of the Plan is The Thryv Plan for Employee Group Insurance, and the plan number is 511. Internal Revenue Code Section 125 benefits are provided through The Thryv Cafeteria Plan (the “Cafeteria Plan”).

Plan Type

The Plan is a welfare benefit plan providing health, dental, vision, prescription drug, flexible spending accounts, a wellness program, short-term and long term disability benefits, life and accidental death & dismemberment insurance, an employee assistance program, and other welfare benefits.

Employer Identification Number

The Employer Identification Number (EIN) for the Plan is13-2740040.

Plan Year

The **plan year** for the Plan and the Cafeteria Plan is the 12-consecutive-month period beginning January 1 and ending December 31.

Plan Administrator

The **Plan Administrator** for the Plan and the Cafeteria Plan is the:

Thryv Holdings, Inc.

Employee Benefits and Asset Management Committee
2200 West Airfield Drive
P.O. Box 619810
DFW Airport, TX 75261-9810
1-972-453-7000

Plan Sponsor

The Plan Sponsor for the Plan and the Cafeteria Plan is:

Thryv Holdings, Inc.
2200 West Airfield Drive
P.O. Box 619810
DFW Airport, TX 75261-9810
1-972-453-7000

Agent for Service of Legal Process

The agent for service of legal process is the **Plan Administrator**. Any legal process regarding the Plan should be delivered to the **Plan Administrator** at the following address:

Thryv Holdings, Inc.
Employee Benefits and Asset Management Committee
2200 West Airfield Drive
P.O. Box 619810
DFW Airport, TX 75261-9810
1-972-453-7000

In addition, a copy of the legal process involving this Plan must be delivered to:

CT Corporation System
350 North St. Paul, Suite 2900
Dallas, TX 75201

Source of Contributions

Contributions to the Plan are a combination of employer and employee contributions. If you participate in the Plan, the **Company** pays all, part of, or none of the amount that is needed to pay for Plan benefits, and you pay the rest. In other words, some benefit coverages are fully-paid by the **Company**, some benefit coverages are fully-paid by you, and some benefit coverages are paid in part by the **Company** and in part by you.

Funding Medium

Benefits under the Plan that are self-insured are funded through the general assets of the **Company** with certain benefits insured with a stop loss insurance policy. Any fully-insured benefit coverages are funded currently through insurance contracts with the **claims administrators**.

To Whom the Plan Pertains

The Plan pertains to the eligible employee groups of Thryv Holdings, Inc. which has adopted the Plan. The **Company** includes any other entity whose participation in the Plan is approved, including Thryv, Inc. You may examine or receive from the **Plan Administrator**, upon written request, information as to whether a particular entity is participating in the Plan, and if so, that organization's address.

Claims Administrator's Authority to Review Claims

For full details on how to file a claim or appeal, see the "Claims and Appeals Procedures" section.

Special Rules for Severance Agreements and Severance Plans

You may become eligible for a separation agreement or separation program offered by the **Company**. The **Company** severance plan will identify which benefit coverages, if any, are continued post-employment and the extent to which a **Company** subsidy is provided (if any) following your separation.

Subrogation Provision

If you recover any charges for covered expenses from a third party (e.g., as a result of a lawsuit from an automobile accident), the Plan's provisions for subrogation and reimbursement take effect. Under these provisions, the **claims administrator's** subrogation vendor will try to recover money that has been paid (or should be paid) on behalf of a third party (the other driver, in this example) whose negligence or wrongful actions caused **illness** or **injury** to a Plan participant. In this example of a car accident, should the Plan provide benefits because of your accident, the Plan has the right to recover the amount of these benefits from the negligent person or by obtaining a reimbursement from that person's insurance company—or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Plan and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages. As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the **claims administrator's** subrogation vendor in carrying out the Plan's subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the **claims administrator's** subrogation vendor and take what action the **claims administrator's** subrogation vendor

requests to help recover the value of benefits provided under the Plan. If you do not, any amounts that could have been recovered through subrogation may be deducted from future Plan payments on your and your dependents' behalf.

The covered person must sign any documents requested by the Plan to enable the Plan to exercise its rights under this provision. The Plan is not responsible for your legal costs.

Recovery of Overpayment

The Plan has the right at any time to recover any overpayment from the person to whom or on whose behalf payment was made and/or offset the amount of any overpayment from a future claim payment.

The Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. ***Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a Qualifying Event under COBRA***. A COBRA Qualifying Event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Coverage in Event of Leave under FMLA. If you are on a family or medical leave of absence that meets the eligibility requirements under FMLA, coverage under the Plan will be continued in accordance with state and federal FMLA regulations, provided that you have written approved leave from the absence and leave administrator.

Coverage will be continued for up to the greater of:

- the leave period required by the federal Family and Medical Leave Act of 1993, as amended; or
- the leave period required by applicable state law.

Continuation Rights Under COBRA

Overview

A federal law known as the **Consolidated Omnibus Budget Reconciliation Act of 1985**, as amended (**COBRA**), requires most employers that sponsor health care benefit plans to offer employees and eligible members of their families the opportunity to extend health care coverage temporarily at group rates after coverage under the Plan would otherwise end. The extension of coverage to employees and their eligible dependents is called "continuation coverage." Your right to continue coverage through **COBRA** is subject to all applicable federal laws and regulations. This section highlights continuation coverage under **COBRA**. The Thryv Benefits Center administers **COBRA**. Therefore, be sure to contact the Thryv Benefits Center by phone for any **COBRA**-related transactions.

In general, the coverages that may be continued are the same as the coverages (medical [includes prescription drugs], dental, vision, EAP, and/or Health Care FSA) in which you and your eligible dependents were enrolled under the Plan as an active employee on the day before a "qualifying event" occurred, provided such coverage is still offered by the **Company**.

Some states may provide **COBRA** rights that are more favorable than those described in this summary. This means that you could be entitled to additional continuation coverage if you're a resident of such state. Contact the COBRA unit at the Thryv Benefits Center for further information.

Qualifying Events and Maximum COBRA Periods

To be eligible for continuation coverage, a qualifying event must take place and as a result, you must lose coverage. After the qualifying event, continuation coverage must be offered to each person who is a continuation coverage beneficiary.

The chart below lists the maximum required continuation periods available to continuation coverage beneficiaries under **COBRA**, based on specific qualifying events that would otherwise result in a loss of coverage subject to continuation. Continuation coverage beneficiaries must elect medical (includes prescription drugs), dental, vision, EAP, and/or Health Care FSA coverages under the Plan within 60 days of the qualifying event to be eligible for continuation coverage.

A child who is born, adopted, or placed with you for adoption during a period of continuation coverage may be added to the coverage. As long as you notify the Thryv Benefits Center within the 60-day period, coverage begins as of the date of birth, adoption, or adoption placement. The child will have all of the continuation coverage rights that any other covered dependent would otherwise have. "Important Notes" and "About the Disability Extension" under this section also contain important details regarding qualifying events and **COBRA** periods.

Continuation Coverage

The chart below lists the qualifying events and the maximum continuation periods available to continuation coverage beneficiaries under **COBRA**.

Qualifying Event	Maximum Continuation Coverage Period*
▪ Termination of your employment (other than for gross misconduct) ▪ Reduction in your hours of employment that would cause you to lose eligibility ▪ Retirement	You and your covered dependents have the right to continue medical (includes prescription drugs), dental, vision and/or EAP coverage for up to 18 months You and your covered dependents have the right to continue Health Care FSA through the end of the calendar year in which the qualifying event occurred
▪ Your death ▪ Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order provides otherwise) ▪ Your child no longer meets the definition of an eligible dependent under the Plan ▪ You become entitled to Medicare**	You or your covered dependents have the right to continue medical (includes prescription drugs), dental, vision and/or EAP coverage for up to 36 months You and your covered dependents have the right to continue Health Care FSA through the end of the calendar year in which the qualifying event occurred
▪ You or your covered dependents are determined to be disabled under Title II or XVI of the Social Security Act	The initial 18-month period of continuation coverage may be extended for medical (includes prescription drugs), dental, vision and/or EAP coverage for up to 11 months (for a total of up to 29 months of continuation coverage). See "About the Disability Extension" under this section for details.

* The duration of coverage starts the day after your coverage ends following the date of the qualifying event.

** The 36-month coverage begins on the day you enroll in **Medicare**.

Important Notes

If a second qualifying event (that is not termination of employment or reduction in your hours of employment) occurs within the 18 or 29-month period, the **COBRA** continuation period for medical (includes prescription drugs), dental, vision and/or EAP coverage may be extended for up to 36 months from the first qualifying event. Notify the Thryv Benefits Center within 30 days if a second qualifying event occurs during a continuation coverage period.

A continuation coverage beneficiary does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to

eligibility under the Plan. The Plan reserves the right to terminate a continuation coverage beneficiary's continuation coverage retroactively if such continuation coverage beneficiary is determined to be ineligible.

About the Disability Extension

The Social Security Administration (SSA) may determine that you were disabled at any time within 30 days of the qualifying event (e.g., the disability began at some time before the 60th day of continuation coverage, and continued at least until the end of the 18-month continuation coverage period). The 11-month extension applies to all disabled and non-disabled continuation coverage beneficiaries entitled to continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the notice requirements (see "Reporting a Qualifying Event" under this section for details).

You must notify the Thryv Benefits Center about the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month continuation coverage period to receive extended coverage. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. Continuation coverage ends on the first day of the month that is 31 or more days after the SSA's determination that the disability has ended.

Who is a COBRA Continuation Coverage Beneficiary

Any of the following could become continuation coverage beneficiaries if medical (includes prescription drugs), dental, vision, EAP, and/or Health Care FSA coverage under the Plan is lost because of a qualifying event:

- You;
- Your covered **spouse**; or
- Your covered child(ren).

Reporting a Qualifying Event

You must notify the Thryv Benefits Center by phone or in writing within 30 days of the date on which any of the following qualifying events occur and result in your and/or a covered dependent's loss of medical (includes prescription drugs), dental, vision, EAP, and/or Health Care FSA coverage, unless a different time period is shown).

- You and your **spouse** divorce or become legally separated;
- Your child no longer meets the definition of an eligible dependent under the Plan;
- You (or your covered dependent) are determined to have been disabled under the Social Security Act at any time during the first 30 days of receiving continuation coverage.

The Thryv Benefits Center is automatically notified by the **Company** when any of the following qualifying events occur:

- Your employment hours are reduced and, as a result, you become ineligible for coverage;
- Your employment terminates;
- You die;
- You become entitled to **Medicare** upon attaining age 65; or
- The **Company** files for bankruptcy reorganization.

Deciding Whether or Not to Elect COBRA Continuation Coverage

You receive a notice and an enrollment worksheet from the Thryv Benefits Center generally within 14 days of the date the Thryv Benefits Center receives notification of the qualifying event. Under the law, you and each continuation coverage beneficiary have 60 days to elect continuation coverage from the later of the day:

- Coverage would otherwise end because of a qualifying events described here; or
- The notice of your and your continuation coverage beneficiary's right to elect continuation coverage is sent to you by the Thryv Benefits Center.

Each continuation coverage beneficiary has an independent right to elect continuation coverage. However, covered employees may elect **COBRA** on behalf of their **spouse** and children.

If you and/or your continuation coverage beneficiary do not elect continuation coverage within the 60-day period, your and/or your continuation coverage beneficiary's eligibility under the Plan ends, unless eligibility is extended through other Plan provisions.

Paying for COBRA

To continue your medical (includes prescription drugs), dental, vision, EAP, and/or Health Care FSA coverages through **COBRA**, you and your covered dependents, as applicable, must pay the full cost of coverages, plus a 2 percent fee for administrative costs (102 percent of the full cost of coverages). Or in the case of an 11-month extension due to disability, the full cost of coverages, plus a 50 percent administrative fee (150 percent of the full cost of coverages), unless federal law mandates alternate payment levels and requirements on a temporary or permanent basis. You make this payment during the full period of continuation coverage. If an applicable severance plan provides a partial **Company**-paid COBRA subsidy, you and your covered dependents, as applicable, must pay the full COBRA cost (including administrative cost) less the **Company**-paid amount.

Your first payment is due within 45 days of your election to continue coverage and must include your **COBRA** contributions for the entire period from the date coverages ended through the month of the payment. In certain situations, your first payment may be delayed due to other Plan provisions, such as those provided through a **Company** severance plan. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the Thryv Benefits Center does not receive your monthly contribution within 30 days of the due date, continuation coverage is cancelled as of the last day of the month in which you paid a contribution.

If you do not want to elect continuation coverage, notify the Thryv Benefits Center. If you do not elect continuation coverage, medical (includes prescription drugs), dental, vision, EAP, and/or Health Care FSA coverages under the Plan end as of the day the qualifying event occurs.

When COBRA Continuation Coverage Ends

Continuation coverage continues until the earliest of the:

- End of the applicable 18-month, 29-month, or 36-month continuation coverage period;
- Day a continuation coverage beneficiary fails to pay the required monthly contribution within the 30-day due-date period;
- Day a continuation coverage beneficiary first becomes eligible for coverage under another group health care plan;
- Day a continuation coverage beneficiary first becomes entitled to **Medicare** after the date of his or her continuation coverage election;
- Day that there has been a final determination by the Social Security Administration that the continuation coverage beneficiary who elected to extend coverage for up to 29 months due to a disability is no longer disabled;
- Day of a continuation coverage beneficiary's written request to cancel coverage;
- Day the **Company** ceases to provide any group medical coverage; or
- Date of death.

Trade Act Implications

Special **COBRA** rights under a federal law called the Trade Act of 2002 (the "Trade Act") may apply to you if you have been terminated, or you experienced a reduction of hours and you qualify for a trade readjustment allowance or alternate Trade Adjustment Assistance ("TAA") under a federal law called the Trade Act of 1974. If you qualify, you may be entitled to a second opportunity to elect **COBRA** coverage (if you did not already elect **COBRA**), but only within a limited period of 60 days (or less) and only during the six months immediately following the date your health plan coverage ended. If continuation coverage is elected during this special time period, such coverage is not retroactive to the date of the qualifying event but begins on the first day of the special new 60-day period.

The Trade Act also includes a federal tax credit that continuation coverage beneficiaries who are eligible under the law can use to offset part of the cost of continuation coverage. This special tax credit is available for workers who lose their jobs and are found eligible for TAA benefits, or who are between ages 55 and 64 and receiving monthly benefits from the Pension Benefit Guaranty Corporation (PBGC).

Contact the Thryv Benefits Center promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special **COBRA** rights. For more information about the tax credit, you can contact the Health Coverage Tax Credit Customer Contact Center at 1-855-379-0440. You can find more information online at http://www.doleta.gov/tradeact/.

Important Notices

Plan Audits

The **Plan Administrator** conducts periodic random audits to ensure that coverage is being offered only to those dependents eligible to participate in the Plan. If you're selected for audit, you will be asked to provide **proof** of eligibility. Such **proof** may include copies of your marriage license (or similar documentation), birth certificates, adoption agreements, court custody or guardianship documents, Social Security award notice, and/or a copy of your tax return.

The **Plan Administrator** also conducts periodic audits to ensure that claims are paid correctly. If your claim(s) is identified through the audit, you may be contacted by the auditor or **claims administrator** to verify information about the claim, including other applicable coverage you may have. The **claims administrator** may readjudicate and adjust your claim payment based on the correct application of the benefit provisions.

Release of Health-Related Information—HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As a Plan that offers employees welfare benefit plans under **ERISA**, the Plan is subject to the HIPAA privacy and security rules.

Your **Protected Health Information (PHI)** is subject to safeguard under the privacy and security provisions of HIPAA. Under HIPAA, the **Company** has adopted policies that restrict the use and disclosure of your **PHI**. Generally, use and disclosure without your authorization are limited to payment and health care operation functions, and only the "minimum necessary" information may be used or disclosed. The **Company's** privacy notice fully describes the important uses and disclosure of **PHI**, the **Company's** compliance procedures and responsibilities, your rights under the HIPAA Privacy Rule, and your rights to access **PHI** and make any corrections. If you have any questions regarding HIPAA, please take any of the following steps.

- Review the **Company's** full detailed privacy notice on the Thryv Benefits Center website. You also can request a copy of the notice from the Thryv Benefits Center.
- Call the **claims administrator** or your provider (hospital or **physician**) for questions about your medical history or claims.
- Contact the **Company's** privacy officer with questions or concerns regarding the use of your **PHI**. You can write to:

  Thryv HIPAA Privacy Officer
  Benefits Department
  2200 W. Airfield Drive
  P.O. Box 619810
  DFW Airport, TX 75261

HIPAA Notice of Special Enrollment Rights

THIS NOTICE DESCRIBES SPECIAL CIRCUMSTANCES WHICH MAY ALLOW YOU AND YOUR ELIGIBLE DEPENDENTS TO ENROLL IN THRYV GROUP HEALTH COVERAGE DURING THE YEAR. PLEASE REVIEW IT CAREFULLY.

Thryv Holdings, Inc. sponsors a group health plan (the "Plan") to provide coverage for health care services for our employees and their eligible dependents. The federal Health Insurance Portability and Accountability Act (HIPAA) requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Plan under "special enrollment provisions" described below.

Special Enrollment Provisions

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage. Please contact the Thryv Benefits Center for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the Thryv Benefits Center for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents in the Plan if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. Contact the Thryv Benefits Center for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Contact Information

If you have any questions about this Notice or about how to enroll in the Plan, please contact the Thryv Benefits Center at 1-866-847-1300, option 3, then option 1, for more information.

Notice Availability

Additional information regarding your rights to enroll in the Plan is found in the applicable summary plan description(s) for the Plan, or you may contact the Thryv Benefits Center.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than either of the following:

- 48 hours following a vaginal delivery; or
- 96 hours following a cesarean section.

Federal law, however, 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, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the **claims administrator** for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

If you elect medical coverage under the Plan, services related to a **medically necessary** mastectomy and reconstruction after the mastectomy are considered **eligible expenses**.

These covered services are directly in response to the Women's Health and Cancer Rights Act of 1998. This particular law requires group health care plans and programs that provide coverage for mastectomies to provide benefits for all of the following:

- Services to treat all stages of reconstruction of the breast on which a mastectomy has been performed (if the individual elects breast reconstruction after the mastectomy);
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of any physical complications related to all stages of the mastectomy (including lymphedema).

The covered procedures will be performed in a manner determined in consultation with the attending **physician** and the patient. The Plan pays benefits for **eligible expenses** as appropriate under each coverage option (annual **deductibles** and **coinsurance** levels for each respective coverage option apply).

For additional information regarding covered services related to mastectomies, call the **claims administrator** for your coverage option. See the "Assistance With Benefit Coverages" section for applicable contact information.

Mental Health Parity and Addiction Equity Act Notice

The Plan provides and administer mental health and substance abuse benefits as required by the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). For more information about the Plan and its compliance under the MHPAEA, please contact the Thryv Benefits Center at 1-866-847-1300 (select option #3, then option #1).

Availability of Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) and a Glossary, which summarize important information about any health coverage option in a standard format, to help you compare across options.

The SBC and Glossary are available on the Thryv Benefit Center website (https://MyThryvBenefits.com). Paper copies of these items are also available, free of charge, by calling the Thryv Benefits Center at 1-866-847-1300, option 3, then option 1.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

You may need to take a leave of absence (or military leave of absence) for **uniformed service**. If you're approved for such a leave and you're absent from work because of your **uniformed service** (including Reserve and National Guard duty), you may elect to continue life, AD&D, and health care coverages (medical, [includes prescription drugs], vision, dental, and/or health flexible spending accounts) for yourself and your eligible dependents under the provisions of USERRA.

The period of coverage for you and your eligible dependents ends on the earlier of:

- The end of the 24-month period beginning on the day your military leave of absence begins.
- The day after the day on which you're required but fail to apply for a "return to work."

  Under USERRA, you must apply to "return to work" within specified time periods (depending on the duration of your **uniformed service**).
  - **Uniformed Service** Is Less Than 31 Days: You're generally required to apply to "return to work" on the first full-calendar day of the first regularly scheduled work period following your period of **uniformed service.** (Your period of **uniformed service** ends after you return from your place of service to your residence, plus an eight-hour rest period.)
  - **Uniformed Service** Is Between 31 and 180 Days: You're generally required to apply to "return to work" within 14 days of your discharge.
  - **Uniformed Service** Is at Least 181 Days: You're generally required to apply to "return to work" within 90 days of your discharge.

Please notify the Thryv Benefits Center if you want to continue coverage for yourself and/or your eligible dependents under the USERRA provisions. The Thryv Benefits Center can confirm whether you're required to pay for all or a portion of your coverages.

Be sure to also notify your manager that you will be absent from work due to **uniformed service** (unless you cannot provide such notice because of military necessity or unless under all relevant circumstances, notice is impossible or unreasonable).

Reinstatement of Coverage

If your health care coverages end during your leave because you do not elect coverages to continue under USERRA and you're re-employed by the **Company**, coverages for you and your eligible dependents may be reinstated if:

- You provided the **Company** advance notification (written or verbal) of your **uniformed service** leave; and

- The duration of all of your **uniformed service**-related leaves while you're employed by the **Company** do not exceed a total of five years.

If your coverages under the Plan terminate because you're eligible for similar coverages through the military and your order to active duty is cancelled before your active duty service begins, these reinstatement rights apply.

Applicable Law

The Plan described herein shall be governed and construed in accordance with the laws of the state of Texas to the extent not pre-empted by the laws of the United States (including, but not limited to, **ERISA**).

Your Rights Under ERISA

Receive Information About Your Plan and Benefits

As a participant of the Plan, you're entitled to certain rights and protections under the **ERISA**. **ERISA** provides that all Plan participants be entitled to the following:

- Examine, without charge, at the **Plan Administrator's** office and at other specified locations—such as in worksites and union halls—all documents governing the Plan. These may include insurance contracts, 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 (EBSA) at:

  Public Disclosure Room
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, NW, Room N 15
  Washington, D.C. 20210

- Obtain, upon written request to the **Plan Administrator,** copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The **Plan Administrator** may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

ERISA provides that all Plan participants be entitled to the following:

- Continue health care coverage for yourself, your **spouse**, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event as defined by law. You or your dependents may have to pay for such coverage.

- Review this SPD and the documents governing the Plan for the rules that govern 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 Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants 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 **ERISA** rights.

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 your **ERISA** rights. For instance:

- If you request a copy of the Plan documents or the latest annual report 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 **Plan Administrator's** control.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or if the Plan does not respond to your request concerning the status of a **Qualified Medical Child Support Order (QMCSO)**, you may file suit in a federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money or if you're discriminated against for asserting your **ERISA** rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court decides who should pay court costs and legal fees. If you're 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 the Plan, contact the **Plan Administrator**. If you have any questions about this statement or your rights under **ERISA**, or if you need assistance in obtaining documents from the **Plan Administrator**, contact the nearest office of the Employee Benefits Security Administration (EBSA), 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, DC 20210.

You also may obtain certain publications about your rights and responsibilities under **ERISA** by doing any of the following:

- Calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272;
- Logging in to the Internet at www.dol.gov/ebsa; or
- Contacting the EBSA field office nearest you.