Iron Mountain Incorporated

The Iron Mountain Companies Welfare Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2026

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INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, Benefit Booklets), is intended to serve as the Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by Iron Mountain Incorporated (the Company) under The Iron Mountain Companies Welfare Plan (the Plan) for eligible employees and their eligible dependents.

The Company also offers its employees the Iron Mountain Incorporated Cafeteria Plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide employees Health Care, Limited Purpose Health Care and Dependent Care Flexible Spending Accounts and the opportunity to make pre-tax contributions toward certain benefits. The Company also offers employees enrolled in the high deductible health plan to make pre-tax contributions to a Health Savings Account.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (the Affordable Care Act).

Notwithstanding any other provision in this SPD, Iron Mountain Incorporated intends to operate the Plan in compliance with the transparency, avoidance of surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, Iron Mountain Incorporated will modify this SPD accordingly and/or provide a Summary of Material Modifications.

The Medical, Dental, Short-Term Disability and FSAs are self-insured and provided under other contracts with service providers. All other benefits are provided under insurance contracts. All benefits are summarized in this document and in the Benefit Booklets (as defined below).

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). The Benefit Booklets are provided via the Company intranet at: irm.service-now.com/mymap within the IMBenefits portal. Unless otherwise noted, if there is a conflict between a specific provision under the legal Plan Document and a Benefit Booklet or this Summary Plan Description, the Plan Document controls. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will rule.

The applicable Benefit Booklets describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you. You may also access provider directories on the insurance companies' and HMOs' websites or you can call the insurance companies or HMOs at the phone numbers indicated in the Benefit Booklets. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact Global HR Service Support, 855-462-7547, irm.service-now.com/mymap. The Company reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion. Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by the Company or to interfere with the Company's right to discharge any employee at any time. Providing this SPD to you does not entitle you to benefits for which you are otherwise not eligible.

ELIGIBILITY

ELIGIBLE EMPLOYEES

Generally, you are considered an "eligible employee" and are eligible to participate in the Plan on your date of hire if you are a regular full-time salaried or hourly employee of the Company regularly scheduled to work at least 30 hours-per-week or more.

Certain union employees are eligible for the benefits listed on Appendix B.

Regular part-time salaried or hourly employee of the Company regularly scheduled to work at least 20 hours, but less than 30 hours-per-week are eligible for the benefits listed on Appendix C.

Puerto Rico employees are not eligible for Health Care FSA, Limited Purpose Health Care FSA, Dependent Care FSA, Health Savings Account or Transit/Parking benefits. Medical, Dental and Vision benefits for Puerto Rico employees are provided through Triple-S.

INDIVIDUALS NOT ELIGIBLE

You are not eligible to participate in the Plan if you are:

- Regularly scheduled to work less than 20 hours per week,
- A leased employee,
- An independent contractor,
- A casual employee, or
- A nonresident alien who receives no US source income (within the meaning of the Code) from Iron Mountain Incorporated;
- A member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan as described in Appendix B.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

ELIGIBLE DEPENDENTS

Please see the applicable Benefit Booklets for specific eligibility requirements not outlined below.

Medical, Dental and Vision

The following dependents are eligible for Medical, Dental and Vision coverage offered under the Plan:

- Your spouse, which means a person recognized as married to you by the state, possession or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession or territory of the United States, regardless of where you live;
- Your domestic partner (as defined below);
- Your children or your domestic partner's children through the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;

- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26. Any adult child of your domestic partner who satisfies this definition will also be eligible.

Your dependent children are:

- Your biological children,
- Stepchildren,
- Legally adopted children,
- Children who are placed in your home for adoption, and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Effective January 1, 2020, grandchildren are not eligible.

Your eligible dependents can be enrolled in the Medical (including Telemedicine), Dental and Vision coverage under the Plan only if you (the employee) are enrolled. Your eligible domestic partner's children can be enrolled in the Medical (including Telemedicine), Dental and Vision coverage only if you enroll your domestic partner.

If you enroll your spouse or domestic partner who has access to other employer-sponsored medical coverage, you will pay a surcharge, as communicated in your annual enrollment materials.

If you are married to or in a domestic partnership with another Company employee, you may enroll as an employee under the Plan, but you cannot enroll as both a dependent and an employee. If you are both a Company employee and the dependent of a Company employee, you may enroll as an employee under the Plan or a dependent, but you cannot enroll as both an employee and a dependent. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

In most cases, your coverage terminates as of the date you are no longer eligible. If you elect coverage under the Plan, you agree that you may forfeit contribution amounts that have been deducted from your pay for periods reflecting dates after your coverage ends.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Dependent Life

The following dependents are eligible for Dependent Life coverage offered under the Plan:

- Your legally married spouse, whether of the same or opposite sex;
- Your domestic partner (as defined below);
- Your, your spouse's or your domestic partner's unmarried natural child or stepchild, or legally adopted child under age 26.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Health Care FSA and Limited Purpose Health Care FSA

For purposes of the Health Care Flexible Spending Account (Health Care FSA) and Limited Purpose Health Care Flexible Spending Account (Limited Purpose Health Care FSA) your dependents are:

- Your spouse, which means a person recognized as married to you by the state, possession or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession or territory of the United States, regardless of where you live.;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support; and
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

Dependent Care Flexible Spending Account (Dependent Care FSA)

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code);
- A disabled spouse who lives with you for more than one half the year; and
- Any other relative or household member who receives more than one-half of their support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

Dependents Not Eligible

The following individuals are not eligible for Medical including Telemedicine, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A spouse, domestic partner or a child living outside the United States;
- Your parent or your domestic partner's or spouse's parent.

Domestic Partner and Civil Union Partner Eligibility

Your “domestic partner” means a same-sex or opposite-sex domestic partner of an Iron Mountain Incorporated employee if you both meet the following requirements and complete a Domestic Partner affidavit:

- You are both at least 18 years of age or older and are mentally competent;
- You have a close and committed personal relationship, and you are each other’s sole domestic partner not married to or partnered with any other spouse, spouse equivalent or other domestic partner;
- You have shared the same regular and permanent residence for no less than one year (12 months) and intend to do so indefinitely;
- You are financially interdependent and have proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner’s will; assignment of a durable power of attorney or health care power of attorney; or such other proof as considered by applicable insurance carriers to be sufficient to establish financial interdependency under the circumstances of your particular case;
- You are not blood relatives any closer than would prohibit legal marriage;
- You have registered as Domestic Partners, if required by your State of residence;
- You understand the tax implications of domestic partner insurance and will seek financial counseling on our own if necessary; and
- In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
  - Has signed a Domestic Partner affidavit or declaration with any other person within twelve (12) months prior to designating each other as Domestic Partners hereunder;
  - Is currently legally married to another person; or
  - Has any other Domestic Partner, spouse, spouse equivalent of the same or opposite sex.

Tax Consequences of Domestic Partner Benefits

Unless your domestic partner or their dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner and his or her dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic partner (or their child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- They receive more than 50% of their financial support from you;
- They live with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- They are a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- They are not a section 152 qualifying child dependent on another taxpayer’s filed return or is a section 152 qualifying child dependent on another taxpayer’s return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner and their dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage. In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and their children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify Global HR Service Support, 855-462-7547, irm.service-now.com/mymap immediately of this special state income tax status.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets provided by the applicable Claims Administrator.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of the Company's procedures governing QMCSO determinations, free of charge, by contacting Global HR Service Support, 855-462-7547, irm.service-now.com/mymap

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

You Must Notify the Plan of Certain Events Regarding Your Dependents

If you experience a change in status event, and you want to change your dependent coverage as a result (see the *Making Changes to your Coverage During the Year* section of this SPD), you must notify Global HR Service Support at irm.service-now.com/mymap within 30 days in order to make a change in your election during the year. The notice must be in writing and contain the change in status event, the date of the event, and your requested change and must be sent to the Global HR Service Support at the address in the following paragraph.

In order to preserve your dependent's COBRA rights, you must notify Global HR Service Support at irm.service-now.com/mymap, within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan in such an event, see the *When is COBRA Coverage Available* section of this SPD.

ENROLLMENT

NEW EMPLOYEES

When you begin working at the Company, you will receive the information necessary to enroll in the Plan. If you are an eligible employee (as defined in the *Eligibility* section of this SPD), you are eligible for and will automatically be enrolled in the following Plan benefits:

- Basic Life
- Basic AD&D
- Employee Assistance Plan
- Business Travel Accident (specific eligibility requirements for benefits are described in the policy)
- Short-Term Disability
- Long-Term Disability
- Severance Benefits
- Wellness Benefits

You must affirmatively enroll yourself and your eligible dependents within 30 days of your date of hire for the following Plan benefits:

- Medical (including Teledoc if you are enrolled in an Aetna medical plan)
- Dental
- Vision
- Supplemental Life
- Dependent Life
- Voluntary AD&D
- Health Care FSA
- Limited Purpose Health Care FSA
- Dependent Care FSA
- Health Savings Account
- Group Pre-Paid Legal
- Transit and Parking Benefits
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

If you elect medical coverage under a high deductible health plan and are otherwise eligible, the Company allows you to make pre-tax contributions towards a Health Savings Account. The Company may also make a contribution to your Health Savings Account for you if you are enrolled in a high deductible health plan if you participate in certain wellness programs as described in your enrollment materials.

What Happens if You Don't Enroll When You are First Eligible?

If you and your eligible dependents do not enroll in Medical, Dental, Vision, Health Care FSA, Limited Purpose Health Care FSA or Dependent Care FSA coverage within 30 days of your date of hire, you will have to wait until the next Open Enrollment period to enroll, unless you experience a change in status event (see *Making Changes to Your Coverage During the Year* section of this SPD).

If you do not enroll for Group Pre-paid Legal, Supplemental Life, Dependent Life and Voluntary AD&D coverage when you are first eligible, you may enroll mid-year if you have a change in status.

If you do not enroll for Voluntary Accident Insurance, Voluntary Hospital Indemnity Insurance, and Voluntary Critical Illness Insurance when you are first eligible, you may enroll mid-year if you have a change in status.

When Does Coverage Begin?

Your coverage under the Plan will begin the as of your date of hire. If you become eligible for coverage later than your initial hire, your coverage will begin on the date you become eligible for coverage. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

If you enroll yourself or a dependent in the Medical, Dental, Vision and/or benefits midyear due to a change in status, coverage will be effective the date of the event, but pre-tax payroll contributions will begin prospectively as of the next payroll period following the date Global HR Service Support receives your timely request for enrollment due to a change in status. However, if you have made a change to your medical coverage due to the birth or adoption of a child, your pre-tax contributions will be effective as of the date of the birth or adoption (or placement for adoption). If you enroll in the Health Care FSA, Limited Purpose Health Care FSA or Dependent Care FSA midyear due to a change in status, coverage will be effective as of the next payroll period following the date of your timely request for enrollment.

Please refer to the applicable Benefit Booklets for additional details on eligibility. Although enrollment may be automatic, coverage may not be automatic. If you enroll on time, your coverage will begin on the later of the following: the date you enroll or the date you satisfy the eligibility requirements.

Open Enrollment for Current Employees

Open Enrollment is held every November. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You will receive information, including instructions on how to enroll, before Open Enrollment each year.

HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents (including domestic partners and civil union partners) in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other non-COBRA coverage). However, you must request enrollment within 30 days after your or your eligible dependents' other, non-COBRA coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent childrenin the Plan's Medical benefits. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of event.

The Plan recognizes a HIPAA special enrollment window for employees and dependents (including domestic partners and civil union partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium

assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact Global HR Service Support, 855-462-7547, irm.service-now.com/mymap.

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

Iron Mountain has established a premium conversion plan under Internal Revenue Code Section 125 so that you will be able to pay your share of certain Plan benefits on a pre-tax basis. You pay your share of the cost of the Medical, Dental, and Vision coverage you elect for yourself, your spouse and any tax dependents on a **pre-tax basis**. Please see the *Contributions for Non-Tax Dependents* section below for a description of how your contributions are handled if your enrolled eligible dependents are not eligible for tax-free coverage. The level of contribution is determined by the Company.

Contributions to the Health Care FSA, Limited Purpose Health Care FSA and Dependent Care FSA are also on **a pre-tax basis**. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. If you are enrolled in the high deductible health plan you may make pre-tax contributions to a Health Savings Account.

If you are enrolled in Supplemental Life, Dependent Life, Group Pre-paid Legal, Voluntary AD&D, Voluntary Accident Insurance Voluntary Hospital Indemnity Insurance, and/or Voluntary Critical Illness Insurance coverage, you pay the cost for coverage on an after-tax basis. Contributions are deducted from employees' paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be notified with payment information.

CONTRIBUTIONS FOR NON-TAX DEPENDENTS

If you elect Medical, Dental and Vision coverage for your eligible domestic partner and their eligible children, you will be asked if they are your federal tax dependents at the time of enrollment. If you do not indicate that they are your federal tax dependents, you will be required to pay contributions for domestic partner coverage on an after-tax basis and the amount the Company contributes toward your domestic partner's coverage will be treated as imputed income. The amount of your imputed income will be added to your paychecks each payroll period and will be subject to income tax withholding. In addition, the Company will include the annual amount of this imputed income on your W-2 Form at the end of each year. Before enrolling your domestic partner and their eligible children, you should talk to your tax advisor about the tax implications for you.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment remain in effect for the following plan year (January 1 through December 31), except as described in this section.

CHANGES IN STATUS

Legal, Supplemental Life, Dependent Life and Voluntary AD&D Mid-Year Changes

You may make changes to your Group Pre-paid Legal, Supplemental Life, Dependent Life and Voluntary AD&D elections during the Plan Year**,** if you have a change in status.

Voluntary Benefits Mid-Year Changes

You may make changes to your Voluntary Accident Insurance, Voluntary Hospital Indemnity Insurance, and Voluntary Critical Illness Insurance elections during the Plan Year if you have a change in status.

Medical, Dental, Vision, and FSA Mid-Year Changes

You may be able to change your Medical, Dental, Vision, and Health Care FSA, Limited Purpose Health Care FSA or Dependent Care FSA elections during the Plan Year if you experience a change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify the Company within 30 days of the event, or 60 days for changes related to losing eligibility for Medicaid or CHIP coverage or gaining eligibility for a state's premium assistance program (see *HIPAA Special Enrollment Events* section). If you do not notify the Company within the 30-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree, etc.). The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Change in domestic partnership or civil union partnership status:** Dissolution of a domestic partnership or civil union partnership;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status:** An event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - An increase or reduction in hours that affects eligibility for some or all benefits; and
  - Changing from part-time to full-time employment or vice versa.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;

- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area;
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA);
- **FMLA leave:** Beginning or returning from an FMLA leave;
- **Enrollment in a health plan offered through the public Marketplace:**
  - If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop group health plan coverage under this Plan, even if you remain eligible for coverage under this Plan.
  - If your enrolled dependent(s) becomes eligible for a special enrollment period to enroll in public Marketplace coverage, or they enroll during the public Marketplace's annual open enrollment period, you may drop coverage for them under this Plan, but remain enrolled for yourself (and any covered dependents who did not move to the Marketplace).
  - Any individual whose coverage is dropped at this time must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day coverage under this Plan is dropped.
  - You are not permitted to change your Health FSA elections because you or your dependent intend to enroll in a plan offered through the public Marketplace.

Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, changes as a result of a reduction in hours of service, and changes because of your enrollment in a health plan offered by the public Marketplace, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental, Vision and Health Care FSA or Limited Purpose Health Care FSA elections.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

COVERAGE CHANGE EVENTS

In some instances, you can make elections if the type of coverage changes. These rules do not apply to a Health Care FSA or Limited Purpose Health Care FSA. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Coverage Changes

The following are additional situations in which you may change your current coverage.

Changes in Coverage under Another Employer Plan — If your spouse or dependent child(ren) is employed and their employer's plan allows for a change in your family member's coverage (either during that employer's Open Enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during their employer's open enrollment period, you may request to end your coverage under the Plan.

Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

Dependent Care FSA Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care FSA if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases or decreases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or
- You make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, please refer to your Benefits Guide.

FMLA LEAVE

The federal Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying necessity that arises from a family member's active duty or call to active duty in the Armed Forces or a military reserve unit from the National Guard, Military Reserve or retired status in the Armed Forces or Reserve. This leave is also available for family members of veterans for up to five years after a veteran leaves service if they develop a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please refer to your Benefits Guide.

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, Employee Assistance Plan, Wellness and Health Care FSA or Limited Purpose Health Care FSA coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by paying for coverage during your leave on an after-tax basis, and/or catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the leave.

If your Health Care FSA or Limited Purpose Health Care FSA coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

Your Basic Life, AD&D, Business Travel Accident, Short-Term Disability and Long-Term Disability coverage will continue during an FMLA leave. Your Supplemental Life, Dependent Life, Voluntary AD&D, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Hospital Indemnity Insurance, and Voluntary Critical Illness Insurance coverage will also continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. Your contributions to the Dependent Care FSA will be suspended once your leave begins.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care FSA election.) Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see the *COBRA* section of this SPD).

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Employee Assistance Plan, Wellness and Health Care FSA or Limited Purpose Health Care FSA coverage for up to 24 months as long as you give the Company advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from the Company, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

All other coverages will continue during your military leave for 30 days. However, participation in the Dependent Care FSA will terminate. If you are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA Plan Year (extended for the 2-1/2 month grace period).

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, by termination of the insurance contract or agreement, or by discontinuance of contributions by the Company;
- The date you cease to be employed in one of the eligible classes. This includes your death, reduction in hours, or termination of active employment;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain medical procedures or exclusions due to pre-existing conditions on benefits other than Medical benefits) are described in the Benefit Booklets.

Coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- The date that your spouse or other dependents' coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, by termination of the insurance contract or agreement, or by discontinuance of contributions by Iron Mountain;
- For your dependent child, for Medical, Dental and Vision coverage, the end of the month in which they attain age 26 (unless they are mentally or physically disabled and primarily depends on you for support);
- The day your legally married spouse, domestic partner or child is no longer considered an eligible dependent (for example, for a spouse, the date of divorce);
- The end of the pay period in which you stop making contributions required for dependent coverage; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage due to certain specified situations.

Federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. As such, a domestic partner has no independent right to continue group health plan coverage after a dissolution of domestic partnership or the employee's death. But a former employee has a COBRA right to retain a domestic partner's coverage and to elect domestic partner coverage during Open Enrollment if similarly situated active employees can do so.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, Employee Assistance Plan, Wellness, and Health Care FSA or Limited Purpose Health Care FSA benefits. COBRA does not apply to any other benefits offered under the Plan or by the Company (such as Life, LTD, or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

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

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to the Company, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of employment with the Company or
- The termination of your employment with the Company (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with the Company (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with the Company; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with the Company (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform the Company that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the former employee of the Company, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the Company (see Contact Information) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the Company within the 30 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Company during the covered employee's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the Company of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify the Company (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Company requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to the Company at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to the Company within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to the Company or the COBRA Administrator.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose their right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, they become entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). When you complete the election form, you must notify the Company if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care FSA or Limited Purpose Health Care FSA COBRA Coverage

COBRA coverage for the Health Care FSA or Limited Purpose Health Care FSA, if elected, will consist of the Health Care FSA or Limited Purpose Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care FSA or Limited Purpose Health Care FSA will be covered together for Health Care FSA or Limited Purpose Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA or Limited Purpose Health Care FSA annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

COBRA premiums may be paid by check or money order or ACH payment, as permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you

make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care FSA or Limited Purpose Health Care FSA ends on the last day of the Plan Year in which the qualifying event occurred, but claims incurred during the grace period are eligible for reimbursement. COBRA coverage for the Health Care FSA or Limited Purpose Health Care FSA cannot be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.; and
- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or COBRA initial notice, of both the responsibility to provide the notice of

disability determination and the Plan's procedures for providing such notice to the COBRA Administrator.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant); and (3) and the date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or COBRA initial notice, of both the responsibility to provide the notice of disability determination and the Plan's procedure for providing such notice to the COBRA Administrator. The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Company no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee), but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied;
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the Company reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

The Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act restrict the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Company, the insurance carriers and/or HMOs

may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible after the Medicare initial enrollment period because you are still employed and enrolled in Iron Mountain's Plan, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends, or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later.

If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information on Medicare, special enrollment periods, and coordination with your group health plan coverage and/or COBRA, visit https://www.medicare.gov/medicare-and-you.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

Global HR Service Support
Iron Mountain Incorporated
1101 Enterprise Dr.
Royersford, PA 19468
(855-462-7547)

COBRA Administrator
Fidelity
1-833-299-5089
www.netbenefits.fidelity.com

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Company informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Company or the COBRA Administrator.

Special COBRA Rights for California Employees

If you are enrolled in a medical HMO or insured medical coverage in California at the time your federal COBRA coverage is exhausted, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost). This special California continuation benefit is provided by the HMOs and insurance companies and is not Iron Mountain Incorporated's responsibility. Contact your HMO or insurance carrier to find out whether you are eligible for this continuation benefit and how to obtain it.

Converting Coverage After Termination

If you are eligible to convert your coverage to an individual policy, you will be sent a conversion notice within the last 180 days of COBRA coverage. Contact the applicable HMO or insurance company for information on converting to an individual policy. HMOs and insurance companies will sometimes permit you to continue membership or equivalent coverage under an individual policy. Conversion rights may also be available to your spouse and/or dependent children. However, the cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as the Plan. For more information about conversion rights, contact the applicable HMO or insurance company.

COVERED AND NON-COVERED SERVICES

Refer to the Benefit Booklets provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

TRANSGENDER REASSIGNMENT (SEX CHANGE) SURGERY & COUNSELING COVERAGE UNDER THE AETNA MEDICAL PLAN

If you are covered for Medical benefits under the Plan with Aetna, eligible health services include services and supplies for transgender reassignment (sometimes called sex change) surgery.

You must be at least 18 years old to be eligible for this benefit.

Eligible health services include:

- The surgical procedure
- **Physician** pre-operative and post-operative **hospital** and office visits
- Inpatient and outpatient services (including outpatient surgery)
- **Skilled nursing facility** care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender reassignment counseling by a **behavioral health provider**

The **bold** terms used are as defined in the Aetna Benefit Booklet.

SPECIAL RIGHTS FOR MOTHERS AND NEWBORN CHILDREN

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

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

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

Designation of Primary Care Providers

If you are enrolled in Kaiser HMO that requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, one may be designated for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at the contact information listed on page 36.

For children, you may designate a pediatrician as the primary care provider.

Access to OBGYN

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at the contact information listed on page 36.

HEALTH CARE FSA BENEFITS

The Health Care FSA may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage.

This section explains how the Health Care FSA allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive in health care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the *Eligible Dependents* section of this SPD.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than the amount communicated annually in the Benefits Guide by Iron Mountain per Plan Year of your own money to your Health Care FSA.

ELIGIBLE EXPENSES

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. The Plan will offer a “grace period” where you can continue to incur claims after the end of the Plan Year for reimbursement from unused Health Care FSA funds. This grace period allows you to incur expenses until March 15th following the Plan Year. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with

long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, coinsurance, copayments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care FSA include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except menstrual care products, smoking cessation,and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses that may be eligible for reimbursement under the Health Care FSA:

- Medical Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "reasonable and customary" limits
  - Expenses excluded under the terms of the Medical benefit plan
  - Drugs requiring a doctor's written prescription that are not covered the Medical benefit plan
  - Menstrual care products
  - Personal protective equipment (PPE) for the primary purpose of preventing the spread of COVID-19
  - Over-the-counter drugs, as permitted under applicable law or regulation.
  - Smoking cessation programs and related medicines
  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by a medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).
- Dental Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by a vision plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

INELIGIBLE EXPENSES

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care FSA:

- Premiums
  - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense. This exclusion does not include menstrual care products or PPE.
- Long Term Care Expenses.

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

USE OR LOSE

IRS regulations stipulate that you must use the full amount of money in your Health Care FSA for expenses incurred during the applicable Plan Year or within the 2½ month grace period following the Plan Year (e.g., January 1 to March 15), or forfeit what remains. Your request for reimbursement must be filed by March 31st after the Plan Year in which funds are allocated to your Health Care FSA for expenses incurred during that Plan Year and within the 2½ month grace period following the Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Health Care FSA. Set aside only as much as you expect to claim during the Plan Year and within the 2½ month grace period following the Plan Year, or you will lose it.

You may not use money in your Health Care FSA to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a weekly basis. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

If you have incurred claims during the grace period, but have also elected a Health Care FSA for the following Plan Year, your claims will be reimbursed first from any balance remaining in your prior Plan Year account, and then from your current Plan Year account.

All claims for a Plan Year and the 2½ month grace period following the Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care FSA is Fidelity.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Unless you elect to continue your Health Care FSA coverage under COBRA (see *COBRA* section above), your Health Care FSA coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed from your Health Care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

LIMITED PURPOSE HEALTH CARE FSA BENEFITS

If you are participating in the Plan's high deductible health plan, and are contributing to an HSA, you are eligible to participate in the Limited Purpose Health Care FSA. You are not eligible to participate in the general Health Care FSA.

Generally, the Limited Purpose Health Care FSA operates just like the Health Care FSA described in the prior section, with a few important exceptions indicated below:

- Until or unless your expenses exceed the deductible under the high deductible health plan option you elected, you may only use your Limited Purpose Health Care FSA to obtain reimbursements for:
    - Dental care expenses
    - Vision care expenses
    - Preventive care expenses
- Medical expenses that are not dental, vision or preventive care expenses are not considered eligible expenses except to the extent that they exceed the statutory minimum annual deductible for a high deductible health plan under Code Sec. 223(c)(2)(A)(i), as indexed by the IRS.

Below is a partial list of dental and vision expenses that are eligible for reimbursement under the Limited Purpose Health Care FSA, to the extent they are not otherwise covered by your health plan(s):

- Vision care expenses
  - Eyeglasses
  - Prescription sunglasses
  - Contact lenses and supplies
  - Ophthalmologist fees
  - The cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)
  - Laser surgery
- Dental care expenses
  - Anesthesia
  - Cleaning
  - Charges in excess of Usual and Prevailing Fee Limits
  - Drugs and their administration
  - Experimental procedures
  - Extra sets of dentures or other dental appliances
  - Medically necessary orthodontia expenses for adults or dependents
  - Myofunctional therapy
  - Replacement of dentures or bridgework
  - Replacement of lost, stolen, or missing dentures or orthodontic devices

DEPENDENT CARE FSA BENEFITS

The Dependent Care FSA may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Dependent Care FSA allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed in the *Eligible Dependents* section of this SPD.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than the amount as communicated annually in the Benefits Guide by Iron Mountain per Plan Year of your own money to the Dependent Care FSA.

The IRS limits the amount you may contribute to your Dependent Care FSA. There is an overall annual maximum of $7,500 (or $3,750 each if you and your spouse file separate income tax returns), but the limit that applies for you is that which has been communicated to you annually herein and within applicable enrollment materials, which may be less than the maximum permitted by the IRS. Additionally, another limitation may also apply. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual

earnings. If you are a highly compensated employee, the Company may implement a lower cap on your contributions.

For example: During the calendar year, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care FSA will be limited to $3,600. She can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or $500 a month.

ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Dependent Care FSA include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you're married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. The Dependent Care FSA will offer a "grace period" where you can continue to incur claims after the end of the Plan Year for reimbursement from unused Dependent Care FSA funds. This grace period allows you to incur expenses until March 15th following the Plan Year.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

INELIGIBLE EXPENSES

You cannot use the money in your Dependent Care FSA to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition

- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the FSA.

USE OR LOSE

It is important that you not contribute more than the dependent care expenses that you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care FSA for expenses incurred during the Plan Year and within the 2 ½ month grace period following the Plan Year (e.g., January 1 to March 15), or forfeit what remains. You must incur eligible expenses by March 15th in order for them to be eligible for reimbursement. Your request for reimbursement must be filed prior to March 31st after the Plan Year in which funds are allocated to your Dependent Care FSA for expenses incurred during the Plan Year and within the 2 ½ month grace period following the Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care FSA. Set aside only as much as you expect to claim during the Plan Year and within the 2 ½ month grace period following the Plan Year or you will lose it.

You may not use money in your Dependent Care FSA to pay health care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a weekly basis. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

If you have incurred claims during the grace period, but have also elected a Dependent Care FSA for the following Plan Year, your claims will be reimbursed first from any balance remaining in your prior Plan Year account, and then from your current Plan Year account.

All claims for a Plan Year and the 2 ½ month grace period following the Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Dependent Care FSA is Fidelity.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Only claims incurred on or before your date of termination may be reimbursed from your dependent care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

SPECIAL RULES AFFECTING DEPENDENT CARE FSAS

Several special rules apply to Dependent Care FSAs. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care FSA. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care FSA. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Flexible Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care FSA even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

CLAIMS AND APPEAL PROCESS

FILING A CLAIM

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. In general, any participant or beneficiary under the Plan may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets. In general, any participant or beneficiary under the Plan (or their authorized representative) may file a written claim for benefits using the proper form and procedure.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse or child) must submit a written request on a form approved by the Plan Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed below), a participant's or beneficiary's treating physician or other health care professional may act as an authorized representative in exercising a participant's or beneficiary's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a participant's or beneficiary's behalf. Any attempted assignment of benefits by a participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the Plan.

Claims Administrators – Fully Insured Plan Benefits

The following benefits under the Plan are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Information on how to contact the Claims Administrators can be found in your Benefits Guide.

HMO Medical	Kaiser Permanente
Puerto Rico Medical, Dental & Vision	Triple-S
Vision	VSP
Basic, Supplemental & Dependent Life, Accidental Death and Dismemberment (AD&D)	Lincoln Financial
Long-Term Disability (LTD) Insurance	Lincoln Financial
Business Travel Accident	AIG
Group Pre-paid Legal	Hyatt Legal
Employee Assistance Plan	Aetna Resources for Living
Voluntary Hospital Indemnity Insurance	Aetna
Voluntary Accident Insurance	Aetna
Voluntary Critical Illness Insurance	Aetna
Wellness	Aetna

International Expatriate Medical	Cigna International

Claims Administrators – Self-Insured Plan Benefits

The following benefits are self-insured. The Company has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment under the self-insured benefits and the Health Care FSAs. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Information on how to contact the Claims Administrators can be found in your Benefits Guide.

PPO Medical Network, Value, Savings, & Upfront Advantage benefit options	Aetna
Dental	Delta Dental
Short-Term Disability	Lincoln Financial
FSAs	Fidelity
Severance Benefits	Self-administered

This section provides general information about the claims and appeals procedure applicable to certain Plan benefits under ERISA. (The *Administrative Information* section of this SPD identifies which Plan benefits are *not* subject to ERISA. These claims and appeals rules do not apply to those benefits.) Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information. **If there are any discrepancies between the claims and appeals procedures in this summary and the applicable Benefit Booklet, then the Benefit Booklet will govern.**

CLAIM-RELATED DEFINITIONS

Claim

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved. The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

An adverse benefit determination for disability claims or Medical benefit claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

INITIAL CLAIM DETERMINATION

For each of the Plan benefits, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request, and ;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

In the event of an adverse benefit determination for a disability claim, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

For Medical claims, the notice will also include information sufficient to identify the claim involved. This includes:

- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care FSA and Limited Purpose Health Care FSA claims are considered non-urgent "post-service" claims.

	Medical, Dental, Vision, EAP, Wellness & Health Care FSA Plans				Short-Term & Long-Term Disability	Life, AD&D, Severance, Business Travel,Legal & Voluntary
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Dental, Vision, EAP, Wellness & Health Care FSA Plans				Short-Term & Long-Term Disability	Life, AD&D, Severance, Business Travel,Legal & Voluntary
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	As appropriate to type of claim	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

APPEALING A CLAIM

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the *Filing a Claim* section of this SPD. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take 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.

For disability claims and for Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

For disability claims and for Medical claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify you of the resubmission.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the *Time Frames for Appeals Process* section of this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health benefit under the Plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

For Medical claim adverse benefit determinations, the notice will also include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- A description of any applicable contractual limitations period, including the date on which the claim expires;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

Unless the right to an external review applies under the Medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review

For Medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission, or, in the event there is a question as to whether the claim should have been subject to surprise billing protections, as required by the No Surprises Act provisions of the CAA. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator's decision and provide you with a written determination, as described in the Benefits Booklets.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law.

The external review process does not apply to any other adverse benefit determination or final internal adverse benefit determination.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical, Dental, Vision, EAP, Wellness & Health Care FSA Plans			Short-Term & Long-Term Disability	Life, AD&D, Severance, Legal, Business Travel & Voluntary Benefits
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Appeals Process For Benefit Administration Decisions (such as Denial Of A Life Event)

If you receive notice of a denial or an adverse benefit determination regarding a decision from benefit administration, such as an eligibility determination or a denial of an election change due to a life event, and you disagree with the decision, you are entitled to apply for a review of the determination. You (or an appointed representative) can appeal and request a review of the decision within 30 days. The request must be made in writing, and should be filed with the Director of Benefit Strategies. If you don't appeal on time, you lose your right to later object to the decision.

You must provide information that you feel relevant to your appeal and complete an appeals form.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

Your appeal will be reviewed at the first level by the Director of Benefit Strategies.

You will be notified of the decision within 15 days.

If you disagree with the decision upon review, you may request a second level of review. Your appeal will be reviewed at the second level by the Vice President, Total Rewards. You will be notified of the decision at the second level within 15 days.

COORDINATION OF BENEFITS

Coordination with Other Plans

Unless otherwise specified in the applicable Benefit Booklet, the Plan will coordinate benefits with any other health plan that covers you or your eligible dependents under the rules below.

Other health plans with which the Plan will coordinate include:

- Group or nongroup coverage, whether insured or uninsured, including HMOs
- The medical care component of long-term care contracts, such as skilled nursing care;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under federal government programs, except that coverage under a federal government program may be limited to hospital, medical, and surgical benefits of the government program. Coverage does not include Medicare supplemental policies or Medicaid policies; and
- The medical benefits coverage in group or individual automobile "fault" or "no-fault" coverage.

Order of Benefit Determination

The rules below determine whether this Plan or another plan will pay primary (first) or secondary. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this Plan.

- COB/Non-COB Provision: The benefits of a plan which does not contain a coordination of benefits (COB) provision always shall be determined before the benefits of a plan which does contain a COB provision.
- No Fault Auto Insurance: The benefits of the plan which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.
- Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent (unless "Medicare Coordination" below applies).
- Dependent Child/Parents not Separated or Divorced: When this Plan and another plan cover the same child as a dependent of different persons, called "parents":
    (1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

    (2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits. For a dependent who has coverage under either or both parents and also has coverage as a dependent under a spouse's plan, see "Longer-Shorter Length of Coverage" below applies.

- Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    (1) first, the plan of the parent with custody of the child;

    (2) then, the plan of the spouse of the parent with custody of the child;

    (3) then, the plan of the parent not having custody of the child, and

    (4) finally, the plan of the spouse of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year starting before the Plan is given notice of the court decree.

  This Plan will not cover the expenses of any child who does not meet the definition of dependent as defined in this Plan except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

- Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the

other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Continuation Coverage: If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:
    (1) First, the benefits of a plan covering the person as an employee or retiree (or as the dependent of an employee or retiree);

    (2) Second, the benefits of coverage under the continuation plan.

  If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer-Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which has covered the person longer are determined before those of the plan which has covered that person for the shorter time.
- Medicare Coordination
    (1) Employees and/or Spouses Entitled to Medicare Due to Age: Unless an active employee entitled to Medicare due to age gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving their right to Plan benefits, the Plan is primary. With respect to the spouse of an active Employee who is entitled to Medicare due to the spouse's age, unless the employee gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving Plan benefits, the Plan is primary.

    (2) Medicare Disabled Covered Persons: If required by law, the Plan is primary with respect to a covered person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

    (3) Covered Persons with End-Stage Renal Disease: For the period required by law, if any, the Plan is primary with respect to a covered person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

Disagreement on Order of Benefits

If the Plan and the other health plan cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the Plan shall immediately pay half of the claim and will determine its liability following payment, except that the Plan shall be required to pay no more than it would have paid had it been the primary plan.

Facility of Payment

If another health plan provides or pays benefits that should have been provided or paid under this Plan, the Plan has the right to pay to the other plan the amount the Plan Administrator determines is necessary to satisfy this coordination of benefit provision. These amounts are considered benefit payments under this Plan and will operate to discharge the Plan from liability to the extent of such payments.

ACTS OF THIRD PARTIES

When you or your covered dependent are injured, or become ill, because of the actions, or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made on your behalf by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf, or intervene in any pending lawsuit, against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator;
- Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator;
- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary;
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness; and
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. If the Plan must institute proceedings against you for not honoring the Plan's recovery rights under this section, you will be responsible for the costs of collection, including reasonable attorney's fees.

If the "Acts of Third Party" provisions in this SPD conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this SPD will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plan or the right to assert legal or equitable rights, including an administrative claim, action under state law or lawsuit against any of the following: the Plan, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company and any Participating Employers, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plan to any other party, including any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction) or to bring any administrative claim, action under state law or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

MISSTATEMENTS AND MISREPRESENTATIONS

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	Iron Mountain Companies Welfare Plan
Plan Number	510
Plan Sponsor	Iron Mountain Incorporated 1101 Enterprise Dr Royersford, PA 19468 855-462-7547
Employer Identification Number	23-2588479
Plan Administrator	Iron Mountain Incorporated 1101 Enterprise Dr Royersford, PA 19468 855-462-7547
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the following types of benefits: ▪ Medical ▪ Dental ▪ Vision ▪ Employee Assistance Plan ▪ Short-Term Disability ▪ Long-Term Disability ▪ Basic Life Insurance ▪ Supplemental Life Insurance ▪ Dependent Life Insurance ▪ Accidental Death and Dismemberment (AD&D) ▪ Voluntary AD&D ▪ Health Care FSA ▪ Limited Purpose Health Care FSA ▪ Business Travel Accident ▪ Group Pre-paid Legal ▪ Severance ▪ Voluntary Accident Insurance ▪ Voluntary Critical Illness Insurance ▪ Voluntary Hospital Indemnity Insurance Although the Dependent Care FSA, Health Savings Accounts and Transit and Parking Benefits are described in this SPD, they are **not** ERISA plans.

Source of Contributions	Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from the Company, contributions by the employee, or will be shared by the Company and the employee. The cost of Medical, Dental & Vision coverage is shared by the Company and its employees enrolled in those coverages. The Company pays 100% of the cost of the Employee Assistance Plan, Wellness, Business Travel Accident, Long-Term Disability, Short-Term Disability, Basic Life, Basic AD&D and Severance coverage. Employees pay 100% of the Supplemental Life, Dependent Life, Voluntary AD&D, Group Pre-paid Legal, Voluntary Accident, Voluntary Critical Illness, Voluntary Hospital Indemnity Insurance, and contributions to the Transit and Parking Benefits, Health Care FSA, Limited Purpose Health Care FSA and Dependent Care FSA. Where the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. The Company, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Company for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

The Company reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, the Company reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. The Company also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by the Company will be done in accordance with the Company's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan shall terminate unless the Plan is continued by a successor to the Company

If a benefit under the Plan is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Company to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If the entire Plan terminates, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses.

PLAN ADMINISTRATION

The Company is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. The Company has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Company will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor the Company will be liable in any manner for any determination made in good faith.

The Company may designate other organizations or persons to carry out specific fiduciary responsibilities for the Company in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Company will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

POWER AND AUTHORITY OF THE INSURANCE COMPANY

Certain benefit programs (identified in the *Filing a Claim* section of this SPD) under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between the Company and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not the Company.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan;
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan;
- The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

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 you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets 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, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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 (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Office of Outreach, Education, and Assistance
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.

APPENDIX A — BENEFIT BOOKLETS

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as "Benefit Booklets") provided by the insurance companies and service providers.

The Benefit Booklets are intended to describe the Company benefits available to you as an employee of the Company, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Benefit Booklets for details of Plan benefits. For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

Coverage	Benefit Booklet Name
PPO Medical - Network, Value, Savings, & Upfront Advantage Plan Options	Aetna Certificates of Coverage
HMO Medical	Kaiser Certificates of Coverage
Puerto Rico Medical	Triple-S Certificate of Coverage
Dental	Delta Dental Certificates of Coverage
Vision	VSP Certificate
Employee Assistance Plan	EAP pamphlet/summary
Basic Life Insurance	Lincoln Financial Certificate of Insurance
Supplemental Life Insurance	Lincoln Financial Certificate of Insurance
Dependent Life Insurance	Lincoln Financial Certificate of Insurance
Short-Term Disability	Lincoln Certificate of Insurance
Long-Term Disability	Lincoln Certificate of Insurance
Accidental Death and Dismemberment	Lincoln Financial Certificate of Insurance
Voluntary AD&D	Lincoln Financial Certificate of Insurance
Business Travel Accident Insurance	AIG Certificate of Insurance
Severance Benefits	Severance Policy
Group Pre-paid Legal	Hyatt Legal Certificate
Voluntary Accident Insurance	Aetna Certificate of Insurance
Voluntary Hospital Indemnity Insurance	Aetna Certificate of Insurance
Voluntary Critical Illness Insurance	Aetna Certificate of Insurance
International Expatriate Medical	Cigna International Certificate

APPENDIX B — UNION COVERAGE

Benefits are available to certain union groups, as described in the following chart:

	Medical, Dental, Vision, Basic Life, Basic AD&D, EAP, Wellness BTA, Basic STD, LT D, Supp Life, Dependent Life, Voluntary AD&D, Health FSA, Limited Purpose Health FSA, Dependent Care FSA, Group Pre-paid Legal, Transit and Parking Benefits	**Basic Life**	**No Benefits**	**Accident, Critical Illness and Hospital Indemnity**
Local #2785		X		
Local #542		X		
Local #986		X		
Local #70		X		
Local #728	X	X		X
Local #853		X		
Local #856		X		
Local #952		X		

APPENDIX C — PART-TIME EMPLOYEE COVERAGE

Part-Time Employees, as defined in the Eligibility section, are eligible for the following benefits under the Plan:

- Aetna Savings Plan
- Delta Dental Plan
- Vision
- Wellness
- Transit and Parking benefits
- Group Pre-Paid Legal
- Employee Assistance Plan
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance