San Francisco Symphony

San Francisco Symphony Health and Welfare Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2026

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

This Wrap Summary Plan Document (SPD) has been formally modified through the Summary of Material Modification document(s) attached at the back of this document.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

"Affiliate" means any corporation or other business entity which is (i) a member of a controlled group of corporations (within the meaning of Section 414(b) of the Code) of which the Company is also a member; (ii) a trade or business under common control with the Company, within the meaning of Section 414(c) of the Code; (iii) a member of an affiliated service group (within the meaning of Section 414(m) of the Code) of which the Company is also a member; or (iv) required to be aggregated with the Company pursuant to regulations issued under Section 414(o) of the Code. An organization which is in an affiliated service group with the Company within the meaning of Code Section 414(m) may not participate in the Plan, but may be required to be aggregated with this Plan for testing and Affordable Care Act reporting purposes.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the applicable regulations promulgated from time to time pursuant thereto.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the applicable regulations issued and effective thereunder.

"Code" means the Internal Revenue Code of 1986, as amended, and the applicable regulations issued and effective thereunder.

"Company" means San Francisco Symphony or any successor thereto, which adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan, and any Affiliate that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the applicable regulations issued and effective thereunder.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable regulations issued and effective thereunder. Compliance with HIPAA is set forth in

Appendix E.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended, and the applicable regulations issued and effective thereunder.

"Plan" means the San Francisco Symphony Health and Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended, and the applicable regulations issued and effective thereunder.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or "dependents." It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs. The Plan includes a Section 125 Program. The Plan and the Section 125 Program are considered a single Plan for purposes of the annual Form 5500 filing requirement. The Plan is filed as plan number 501.

The Plan consolidates a range of welfare plan benefits and contains both ERISA and non-ERISA benefits. Nothing in this Plan document, however, will subject any benefit program to ERISA if the benefit program would not otherwise be covered by ERISA. Such benefit programs may be funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to certain groups of Employees (and their respective covered dependents). Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self- funded is noted in Section 15.

This document and its attachments constitute both the written plan document and summary plan description ("SPD") required by ERISA. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as your responsibilities, under this Plan.

The Plan supersedes and replaces any prior plan document defining the terms of or describing a benefit program which is no longer effective. If the benefit program is insured and there is a conflict between the specific terms of a program document and the terms of the Plan, the program document will control. For all other benefit programs, if there is a conflict between the specific terms of a program document and the terms of the Plan, the Plan will control (unless

contrary to applicable law), except that any terms exclusively applicable to a benefit program will be set forth in the applicable program document.

3. General Information about the Plan

Plan Name:	San Francisco Symphony Welfare Benefits Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	January 1, 1977. The Plan has been amended several times since its original effective date, most recently as of January 1, 2025.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The employer is the Plan Sponsor. San Francisco Symphony 201 Van Ness Ave San Francisco, CA 94102 (415) 503-5318

Plan Sponsor's Employer Identification Number:	94-1156284
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Benefits Manager San Francisco Symphony 201 Van Ness Ave San Francisco, CA 94102 (415) 503-5318
Named Fiduciary:	San Francisco Symphony 201 Van Ness Ave San Francisco, CA 94102 (415) 503-5318
Agent for Service of Legal Process:	San Francisco Symphony 201 Van Ness Ave San Francisco, CA 94102 (415) 503-5318 Service for legal process may also be made on the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document and SPD, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please

review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee who works on average 30 hours per workweek. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the 90-day "lookback period" method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state "premium assistance" through

Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents or as permitted by applicable law. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors to the extent permissible under applicable law. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under

the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For a Health FSA benefit program, COBRA continuation coverage will not be offered with respect to the Health FSA benefit if your Health FSA is overspent, unless otherwise required by applicable law. COBRA coverage for a Health FSA benefit will not extend beyond the end of the plan year (including any grace period) unless the terms of a carryover, as defined by the plan, would apply to qualified beneficiaries and allow access to unused amounts during the following plan year.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document).Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions

toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA,WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996

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

Women’s Health and Cancer Rights Act (WHCRA) of 1998

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

- All stages of 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 of the mastectomy, including lymphedemas.

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

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures

from the Plan Administrator.

Michelle's Law: Mandate on Dependent Student Eligibility

Group health plans and health insurance issuers generally are prohibited from terminating a college student's health coverage on the basis of the child taking a medically necessary leave of absence from school or changing to a part-time status.

The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the Plan because dependent age limitations (i.e. non-student dependent eligibility ending at age 18). The student must have been enrolled in the group health plan before the first day of the leave. There must also be a written certification by the student's physician indicating that the student is indeed suffering from a serious illness or injury that necessitates the leave or change in enrollment status. The coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons, such as aging out of the Plan.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Grandfathered Benefit Programs

The Company has elected to maintain each of the following benefit programs as a "grandfathered health plan" as permitted by the Affordable Care Act:

- Kaiser HMO (Orchestra)

The Plan believes that each of the above listed benefit programs is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on "essential health benefits."

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the US Department of Health and Human Services at www.healthcare.gov.

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not "grandfathered health plans" under the Affordable Care Act:

- Kaiser HMO
- Blue Shield/DHS EPO
- Blue Shield/DHS PPO (Orchestra Only)
- Blue Shield/DHS HDHP

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated "A" or "B"). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan 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.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-

insured benefits.) The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Liability and Indemnification

The Company and any person to whom it may delegate any duty or power in connection with administering the Plan, the Plan Administrator, and the officers and directors of the Company, will be entitled to rely conclusively upon, and will be fully protected in any action taken or suffered by them in good faith in the reliance upon, any accountant, counsel, other specialist or other person selected by the Plan Administrator or in reliance upon any tables, valuations, certificates, opinions or reports which will be furnished by any of them. The Board of Directors and the Plan Administrator (and the individual members thereof) will be indemnified by the Company against any and all liabilities arising by reason of any act or failure to act made in good faith in accordance with the Plan, including expenses reasonably incurred in the defense of any related claim. A Plan fiduciary that is a third party service provider or an insurer will be entitled to indemnification only to the extent provided in a written agreement with such service provider.

Powers and Authority of the Plan Administrator

The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator’s powers will include, but will not be limited to, unilateral discretion to do the following, in addition to any other powers provided by this Plan:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including (i) the establishment of claims review procedures in accordance with Section 503 of ERISA or other applicable law and regulations, (ii) the establishment and communication of QMCSO procedures in accordance with Section 609 of ERISA, and (iii) rules and regulations for the conduct of business by the Administrator;
- To interpret the Plan and to determine all questions arising under or in connection with the Plan, including all questions of eligibility to participate and obtain benefits under the Plan, its interpretation thereof in good faith to be final and conclusive on all interested persons. The Plan Administrator has sole discretionary authority to grant or deny benefits under this Plan. Benefits under this Plan will be paid only if the Plan Administrator or insurer (if applicable) decides, in its sole discretion, that the Participant is entitled to them; provided, however, that the Plan Administrator may delegate to a

claims committee the right and discretion to make determinations as to claims;

- To appoint such agents, counsel, accountants, consultants and other persons (regardless of whether they also provide services to the Company) as may be required to assist in administering the Plan;
- To allocate and delegate its responsibilities under the Plan and to designate other persons from time to time to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;
- To request of and obtain from any Employee, employer, or the Company such information and records as it deems necessary and proper;
- To develop election forms and any other forms necessary for Plan administration;
- To delegate the duty of claims decisions and adjudication to an insurance company or third party administrator. Such insurance company or third party administrator will be the Claims Administrator under this Plan, but only to the extent such powers have been delegated by the Plan Administrator;
- To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits by operation of the Plan;
- To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable sections of the Code;
- To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
- To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines such shall be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan ; and
- To amend or terminate the Plan, in whole or in part, at any time.
- All actions and determinations of the Plan Administrator will be final and binding upon all current Employees, former Employees, participants, dependents, beneficiaries, employers, the Company, and any other interested parties.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Designation of Fiduciaries

The Plan Administrator may designate in writing other persons to carry out a specified part or parts of its responsibilities hereunder (including the power to designate other persons to carry out a part of such designated responsibility), but such designation may not include any power to manage or control assets of the Plan and may not include the power to appoint investment managers. In addition, the Plan Administrator has been designated as a fiduciary of the Plan with respect to the review and determination of benefit claims. The Plan Administrator has been delegated all powers and rights related to such review and determination. The Plan

Administrator has accepted such designation and delegation. The Plan Administrator may designate in writing other persons to carry out a specified part or parts of its responsibilities hereunder (including the power to designate other persons to carry out a part of such designated responsibility).

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) benefits directly to an out-of-network hospital, facility, or other health care provider on behalf of a participant or beneficiary covered under this plan, and such payment will not constitute an assignment of rights or benefits and will not be deemed a waiver of this no assignment provision as to that participant or beneficiary or any other participant or beneficiary covered under this plan.

12. Incompetency

If any person entitled to payments under the Plan's benefit programs is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his or her financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision will apply. If the payment is to be made by an insurance company, such payment will be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Plan Administrator, in its discretion, may

direct that all or any portion of such payment be made:

- to such person;
- to such person's legal guardian or conservator;
- to such person's spouse or to any other person; or
- in any manner the Plan Administrator considers advisable, to be expended for his or her benefit.

The decision of the Plan Administrator (or, where applicable, that of the insurance company) will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred will operate as a complete discharge of the obligations of the Plan, benefit programs, the Company, the employers or Affiliates, the Plan Administrator, and any insurance company, with respect to such payment.

13. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

Exhaustion of Administrative Remedies and Limitations Period

Claimants will not be entitled to challenge the Plan Administrator's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable program document. The decisions made pursuant to applicable administrative claims procedures are final and binding on the claimant and any other party. A benefit program may also permit an external review, such as when required by applicable law.

If the claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his or her right to bring civil action under ERISA Section 502(a), the claimant must bring such action within six (6) months from the date that the claim and appeal procedure is complete. If the claimant does not bring such action within such six (6) month period, the claimant will be barred from bringing an action under ERISA related to his or her claim. In any case, all claims for benefits must be submitted within twelve (12) months of the date that the claimant knew or reasonably should have known the principal facts upon which the claim was incurred.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

14. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA.

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this

summary annual report);

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

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

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

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within the time limits described in the "Exhaustion of Administrative Remedies and Limitations Period" section of this document. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue

N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

15. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Compliance With Code Nondiscrimination Requirements

This Plan is intended to be nondiscriminatory under applicable provisions of the Code. If the Plan Administrator determines before or during any Plan year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered Employees, to ensure compliance with such requirements or limitation.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount

of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

No Guarantee of Tax Consequences

Neither the Company nor the Plan Administrator makes any commitment or guarantee that

amounts paid to or for the benefit of a participant under this Plan will be excludible from the participant's gross income for federal, state, or local income tax purposes, or that any other federal, state, or local tax treatment will apply to or be available to any participant. Each participant is obligated to determine whether each payment under this Plan is excludible from the participant's gross income for federal, state, and local income tax purposes.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☐ Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes

☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

☐ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

16. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Medical	Self-Funded / Blue Shield / CVS Caremark Delta Health Systems	W0054375	Orchestra: All employees Administration: Full time employees working 30+ hours per week	Date of hire	End of the month following date of termination or as outlined in the CBA	Delta Health Systems at: Member Services / Claims P.O. Box 272540 Chico, CA 95927-2540 (800) 422-6099
Medical	Fully-Insured / Kaiser Foundation Health Plan, Inc.	7347	Orchestra: All employees Administration: Full time employees working 30+ hours per week	Date of hire	End of the month following date of termination or as outlined in the CBA	Kaiser at: Kaiser Claims P.O. Box 12923 Oakland, CA 94604-2923 (800) 464-4000
Dental	Fully-Insured / Metropolitan Life Insurance Company	5387450	Orchestra: All employees Administration: Full time employees working 30+ hours per week	Date of hire	End of the month following date of termination or as outlined in the CBA	MetLife at: Dental Claims P.O Box 981282 El Paso, TX 79998 (800) 275-4638
Vision	Fully-Insured / Vision Service Plan (VSP)	604005	Orchestra: All employees Administration: Full time employees working 30+ hours per week	Date of hire	End of the month following date of termination or as outlined in the CBA	VSP at: Member Services 3333 Quality Dr. Rancho Cordova, CA 95670 (800) 877-7195

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
EAP	Fully-Insured / Simple Therapy (Halcyon Behavioral, Inc.)	N/A	Orchestra: All employees Administration: Full time employees working 30+ hours per week	Date of hire	End of the month following date of termination or as outlined in the CBA	Simple Therapy at: Member Services P.O. Box 25159 Fresno, CA 93729-5159 (888) 425-4800
Basic Life/ AD&D/ Supplemental Life	Fully-Insured / Metropolitan Life Insurance Company	5387450	All active employees	Date of hire	Date of Termination or as outlined in the CBA	MetLife at: Life Claims P.O. Box 6100 Scranton, PA 18505-6100 (800) 275-4638
LTD	Fully-Insured / Metropolitan Life Insurance Company	5387450	All active employees	Date of hire	Date of Termination or as outlined in the CBA	MetLife at: Disability Claims PO Box 14590 Lexington, KY 40511-4590 (800) 275-4638
Voluntary Accident and Critical Illness	Fully-Insured / Unum Group	R0586495	Full time employees working 20+ hours/week	Eligibility to enroll in these plans begins on date of hire. Coverage takes effect on the first day of month following or coinciding with the signature date	Date of Termination or as outlined in the CBA	Unum at: Member Services 2211 Congress St. Portland, ME 04122 (800) 635-5597

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
LTC	Fully-Insured / Unum Group	138356	Full time employees working 20+ hours/week	Eligibility to enroll begins on the date of hire. Coverage takes effect on the first day of month following or coinciding with the date of hire	Date of Termination or as outlined in the CBA	Unum at: Member Services 2211 Congress St. Portland, ME 04122 (800) 227-4165
Health FSA and Dependent Care FSA	Fully-Insured / BASIC	FSA: 4819-8024-1701	All active employees. Expenses of spouses and children generally can be reimbursed at employee election	Date of hire	Date of Termination or as outlined in the CBA	BASIC at: Member Services P.O. Box 6278 Monona, WI 53716 (800) 372-3539
HRA	Fully-Insured / BASIC	HRA: 9008-0000-2729	Musicians who are dependents on a spouse/partner's plan (not also enrolled as an employee, if both are active employees).	Date of hire	Date of Termination or as outlined in the CBA	BASIC at: Member Services P.O. Box 6278 Monona, WI 53716 (800) 372-3539

Notes:

1. Please consult carrier documentation for further details regarding which family members are eligible to participate in each of the above coverages.

2. Other Events (Such as fraud or intentional misrepresentation of a material fact) can also terminate coverage--see the benefit program details.

3. The health flexible spending account and DCAP provisions in the Section 125 and/or Section 129 plan(s) are a part of this welfare benefit plan and summary plan description and are incorporated by reference and attached as Appendix C.

Appendix A: COBRA Continuation

See page 23 for the General COBRA Notice

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Kaiser HMO medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

Navia Benefit Solutions
COBRA/DIRECT BILL INFORMATION ENCLOSED
P.O. Box 3961
Seattle, WA 98124

:

GENERAL NOTICE OF YOUR RIGHTS
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.
THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the San Francisco Symphony group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the San Francisco Symphony Plan Administrator at (415) 864-6000. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Qualifying Events

If you are an employee of San Francisco Symphony covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with San Francisco Symphony;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with San Francisco Symphony;
3. The employee's divorce or legal separation;
4. The employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to San Francisco Symphony and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

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.

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the San Francisco Symphony Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. San Francisco Symphony has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the San Francisco Symphony Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, San Francisco Symphony is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the San Francisco Symphony Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the San Francisco Symphony Plan Administrator within 30 days of any final determination that the individual is no longer disabled. If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the San Francisco Symphony Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

Health FSA Information

COBRA coverage under the San Francisco Symphony Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the San Francisco Symphony Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the San Francisco Symphony Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the San Francisco Symphony Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Navia Benefit Solutions at (425) 452-3490 during business hours for more information.

Alternate Recipients Under QMCSOs

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

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.

Plan Contact Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (425) 452-3490 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

San Francisco Symphony
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF ENROLLMENT NOTIFICATION REVISED 11/97

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months. (NOTE: Under the Affordable Care Act, a group health plan must eliminate any pre-existing condition limitations as of the first day of the plan year that begins in 2014.)

CERTIFICATE OF CREDITABLE COVERAGE

If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from San Francisco Symphony About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with San Francisco Symphony and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. San Francisco Symphony has determined that the prescription drug coverage offered by the San Francisco Symphony Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your San Francisco Symphony coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under San Francisco Symphony Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your San Francisco Symphony prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with San Francisco Symphony and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through San Francisco Symphony changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

> Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026
Name of Entity/Sender: San Francisco Symphony
Contact-Position/Office: Benefits Manager
Address: 201 Van Ness Ave., San Francisco, CA 94102
Phone Number: (415) 503-5318

Appendix C: Cafeteria Plan and FSA Provisions

SUMMARY PLAN DESCRIPTION (SPD)
for the
CAFETERIA PLAN, and ACCOUNT PLANS

'You' and 'Your' refer to an Employee who has enrolled in at least one Qualified Benefit Plan for the current Plan Year, or has a carryover balance from an existing Account Plan, when a Carryover is allowed as indicated above. 'You' and 'Your' are also referred to as a 'Participant'.

Purpose. Your Employer has adopted this Plan to allow You to pay for benefit options (called Qualified Benefit Plans) for Yourself, Your spouse, and Your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" Qualified Benefit Plans in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code. This Plan allows You to reduce Your taxable income in direct proportion to (a) Your contribution to the cost of Your elected Qualified Benefit Plans and (b) Your contribution to any Account Plan.

Qualified Benefit Plans. A Qualified Benefit Plan is a tax advantaged Plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Account Plan(s) made available for the current Plan Year is provided above. The list of other Qualified Benefit Plans is provided in the Enrollment Materials provided by Your Employer at the time of enrollment, expressly incorporated by reference into this SPD.

If You are not eligible to participate in this Plan but are allowed to participate in any Qualified Benefit Plan then Your costs will be paid with taxable income and Your compensation will not be reduced by the Employer.

Employer Contributions. Your Employer may provide additional contributions in the way of cash or spending credits that You may use for Qualified Benefits Plans and/or other limited purposes as specified in the Enrollment Materials. These Employer contributions will continue to be provided to You while on approved FMLA Leave to the same extent as they would be provided to an Employee actively at work.

Enrollment Materials. The Enrollment Materials are expressly incorporated by reference into this SPD and include benefit guides and summary benefit descriptions that provide the following detail for the Qualified Benefit Plans offered by Your Employer:

1) The amount of Your Employer's contribution (if any) , the rules regarding how You can use that contribution and any limitation on the use of that contribution set by Your Employer;
2) Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances in which benefits will be coordinated with other sources of payment;
3) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
4) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part (including procedures required under Section 503 of Title I of the Act). Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;
5) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the Participant or beneficiary will be responsible;
6) Any annual or lifetime caps and all other limits on benefits;
7) The extent to which preventive services are covered;
8) Whether, and under what circumstances, existing and new drugs are covered;
9) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
10) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
11) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
12) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to Participants and beneficiaries as a separate document at no charge;
13) Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset,

reduction, or recovery of any benefits; and,

14) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third-Party Administrator.

An Employee's right to enroll in and maintain coverage under the Qualified Benefit Plans are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health Plans are required to cover dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage;
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each Participant, also contains important information about the potential special enrollment rights including a 30 day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice; and,
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid Plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

This Plan defines an eligible Employee to be an individual classified by the Employer as a common-law employee who is typically on the employer's W-2 payroll. 'Employees' does not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Administration. Your Employer acting as the Plan Administrator has sole discretionary powers and is responsible for the administration of this Plan and the Qualified Benefit Plans. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Plan Administrator has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

No Continued Employment. No provisions of the Plan or this SPD grant any Employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

ACCOUNT PLANS

The Account Plans offered for the current Plan Year are listed above on the first page of this SPD. Your Employer appoints BASIC as its Service Provider to maintain certain Account Plan records and to be responsible for the Account Plan's day-to-day administration. BASIC is not a Plan Administrator and has no discretionary authority over the Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this SPD, includes all the information You need to access Your Account Plans and submit requests for reimbursement. By signing into Your online Account Plan, You may access information about Your enrollment, available funds, annual election, total contributions, and total reimbursements.

Age Requirement. No maximum age requirement may be imposed for participation in an Account Plan.

Re-employment of Former Employees. A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original Account Plan elections. A former Employee rehired after thirty (30) days of termination will be allowed to make new Account Plan elections.

Excess Payments. Upon any benefit payment made to an Accountholder in error under an Account Plan, said Accountholder will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Accountholder's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid Request for Reimbursement (RFR) upon request is not provided. The Employer may take reasonable steps to recoup the excess payment including withholding the amount from future salary or wages and subtracting from future benefit reimbursement(s). You will be allowed to submit valid claims to offset any amount due.

Non-Assignment of Benefits. No Accountholder or beneficiary may transfer, assign or pledge any Account Plan benefits except as may be required pursuant to a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), other applicable law, or payment made directly to a healthcare provider.

Termination Of Participation. Accountholders are enrolled in the Account Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be an Accountholder due to the following events:

1) Your death, resignation or termination of employment with the Employer;
2) This Plan terminates;
3) You fail to pay any required premium (including payment by salary reduction) under the Plan;
4) You no longer meet the requirements for eligibility in the Plan; or,
5) You revoke Your election under a qualifying change in status event.

Your actual termination date due to these events will vary depending on the Account Plan and Your Employer's Account Plan design. Check with Your Employer for Your actual termination date. After Your termination in an Account Plan, you can only be reimbursed for services rendered prior to your eligibility end date and submitted before the end of the Run Out Period specified on the first page of this SPD.

Change In Status Events. The laws governing Account Plans generally do not allow You to change Your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in Your account at the close of the Plan Year is forfeited and becomes the property of Your Employer (refer to the first page of this SPD to see if there is a Grace Period or Carryover). This irrevocable election rule does not apply if You experience a qualifying change in status event. The election change request must be on account of and consistent with the change in status event.

Any request to change Your election must be submitted in writing within 30 days of the occurrence of a change in status event. The new benefit elections start after the change in status event has occurred and the paperwork has been filed. This Plan is intended to allow any change in status event that is allowed by the IRS. The following change in status events are applicable:

1) A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
2) The adoption, birth, or death of a child or dependent.
3) Dependent satisfies or ceases to satisfy dependent eligibility requirements.
4) The change in employment status of You, Your spouse or dependent.
5) Change in Your residence. *
6) Beginning or ending adoption proceedings.
7) Automatic changes upon cost increases or decreases. *
8) Significant cost increases. *
9) Significant curtailment of coverage. *
10) Addition or elimination of similar benefits package option. *
11) Change in coverage of a spouse or dependent under an employer Plan. *
12) FMLA.
13) HIPAA special enrollment rights. *
14) COBRA qualifying event.
15) Loss of group health coverage sponsored by governmental or education institution. *
16) A judgment, decree or order requiring coverage for a spouse or child.
17) Medicare or Medicaid entitlement.

18) Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. *
19) Eligibility for Employment Assistance under Medicaid or SCHIP. *
20) Exchange Event – A loss of eligibility under the terms of the Plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements. *
21) Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period. *
22) Exchange Event – Exchange enrollment by one or more of the participant's dependents and/or spouse who are enrolled in the Employer provided group health insurance plan during an Exchange special enrollment period or open enrollment period. (Effective January 1, 2023) *

**These qualifying change in status events do not apply to the Healthcare FSA.*

Notes:
1) If You are making tax free contributions to a Health Savings Account (HSA) under this Plan, You do not need a change in status event to change Your HSA election. You may prospectively change Your HSA election at any time during the Plan Year.
2) For the termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the Employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

Grace Period or Carryover. As a terminated Accountholder, You are not eligible for the Grace Period or Carryover (when offered by Your Employer) unless You are an active Accountholder in the Plan and Your Paid Coverage Period continues through the last day of the Plan Year.

The Family And Medical Leave Act ('THE FMLA') and Unpaid Leave. The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances that are prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave and for unpaid leave for Healthcare Account Plans are:
1) Pre-pay. Under this option, you will pay Your election amounts that will be due during your leave, before your FMLA leave begins. The payments may be either pre-tax or after-tax, according to the terms of your Salary Reduction Agreement.
2) Pay-as-you-go. Under this option, You will pay your share of Your election amounts on the same schedule as if You were not on leave. If You fail to make payments under this Pay-as-you-go option, Your Employer is not required to continue coverage. However, if Your Employer chooses to continue coverage, Your employer is entitled to collect these amounts from you after You return from the FMLA leave.

If a Participant's coverage under the Plan ceased while on FMLA leave, the Participant will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Participant will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Participant can continue with the amount withheld from the Participant's compensation on payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA). The first page of this SPD indicates whether this Plan includes a Healthcare Flexible Spending Account. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder 's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Uniform Coverage Rule. The entire amount of your annual Healthcare FSA election is available to You for services rendered on any day of the Plan Year that you are covered by the Healthcare FSA.

Limitations and Exclusions. The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Healthcare FSA: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for an Accountholder's general wellbeing; items the Accountholder would have purchased even if the Accountholder had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Qualified Reservist Distribution**.** An Accountholder who is called to active duty in the US Armed Services and enrolled in the Healthcare FSA may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Healthcare FSA subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount You have contributed to the account that has not been used to reimburse You for RFRs submitted.

Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of an Accountholder in a group health Plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health Plan under which an Accountholder or other beneficiary is entitled to receive benefits. Accountholders may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

Family and Medical Leave Act (FMLA). If You go on a qualifying leave under FMLA, to the extent required by the FMLA, Your Employer will continue to maintain Your benefit package options providing health coverage (including the Healthcare FSA) on the same terms and conditions as if You were still active (that is, Your Employer will continue to pay its share of the contribution to the extent You opt to continue coverage). Your Employer may require You to continue coverage while You are on paid leave (as long as Accountholders on non-FMLA paid leave are required to continue coverage). If so, You will pay Your share of the contributions by the method normally used during any paid leave.

If Your coverage ceases while on FMLA leave, You will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as You had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which You did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave**.** If You are going on unpaid FMLA leave and You opt to continue Your Medical and Dental Insurance Benefits and Healthcare FSA Benefits, then You may pay Your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during Your leave may be paid either pre-tax or after-tax before Your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
(2) Pay-as-You-go. Your share of contributions will be paid on the same schedule as if You were not on leave or under another schedule. Per the Department of Labor regulations, if You fail to make payments under this option, Your Employer is not required to continue coverage. If Your Employer chooses to make payment and thereby continue coverage, Your Employer is entitled to recoup these amounts from You after You return from leave.
(3) Catch-up. Your Employer may advance Your share of contributions while You are on leave. Upon Your return from leave, Your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with Your Employer to determine if this option is available under Your Plan.

Non-FMLA Leave**.** If You go on an unpaid leave of absence that does not affect eligibility, then You will continue to participate and the contribution due from You will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If You go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave**.** If You take a leave of absence due to military service, You may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Health Savings Account (HSA): If You contribute to a Health Savings Account (HSA) then You may only enroll in a ***Limited Purpose Healthcare FSA*** **(LPFSA**). Qualified Expenses under an LPFSA are limited to dental and vision services or supplies excluded from coverage under Your high deductible health plan, or unpaid amounts incurred after the HDHP statutory annual deductible has been satisfied. The LPFSA will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense or allowed under a General-Purpose Healthcare FSA.

HealthCare FSA Continuation Coverage Rights Under COBRA. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health Plan of the Employer for any calendar year if all employers maintaining such Plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes Your rights for the Healthcare FSA. Your rights under any of the other Qualified Benefits Plans offered by Your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from Your Plan Administrator.

If You elect to participate under the Healthcare FSA and are considered an Accountholder on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of Your qualifying event, the amount of Your annual election less any reimbursed payments is less than the amount of premium required to continue the Healthcare FSA Plan until the end of the Plan Year. COBRA continuation under an excepted Healthcare FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

An Accountholder who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, You will lose Your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of Your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

If You have questions about Your COBRA continuation coverage, You should contact Your Employer or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. The first page of this SPD indicates whether this Plan includes a Dependent Care Flexible Spending Account. This account provides employees with tax free dependent care assistance

only when the assistance is necessary for the Accountholder to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that You could take as a credit against tax on Your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of Your payroll deduction on the date the RFR is processed. The tax laws further limit how much You may contribute to this account.

Under the law and the terms of the Plan, You may defer no more than the lesser of Your actual income for the year (or, if You are married and it is less, Your spouse's actual income) or $5000 per year to this Program. A married Accountholder who files separate tax returns is limited to $2500 per year. A married Accountholder who files joint returns can split this limit as they see fit.

HEALTHCARE PREMIUM (NESP) REIMBURSEMENT ACCOUNT. The first page of this SPD indicates whether this Plan includes a Healthcare Premium (NESP) Reimbursement Account. This account provides reimbursement for premiums You paid for employee-owned health insurance policies. Employer-provided insurance Plans and coverage offered through the Marketplace, (a state or federal Plan under the Affordable Care Act), do not qualify. Premiums eligible for reimbursement are for a period in which You were a covered Accountholder under this account.

REIMBURSEMENT DENIALS FOR ACCOUNT PLANS

Reimbursements under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account. The RFR procedure described below will apply if (a) a RFR under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account components of the salary reduction Plan is wholly or partially denied, or (b) You are denied a benefit under the salary reduction Plan due to an issue germane to Your coverage under the Plan.

If Your RFR is denied in whole or in part, You will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received Your request. (This time-period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where an RFR is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When an RFR is incomplete, the extension notice will also specifically describe the required information, will allow You 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on Your RFR until the specified information is provided.)

Notification of a denied RFR will detail:
- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for You to validate the RFR and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if You wish to appeal the Plan Administrator's decision, including Your right to submit written comments and have them considered, Your right to review (upon request and at no charge) relevant documents and other information, and Your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of Your RFR.

Appeals. If Your RFR is denied in whole or part, then You (or Your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after Your receipt of the notice that the RFR was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your RFR should not have been denied. It should include any additional facts and/or documents that You feel support Your RFR. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed, and a determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your RFR, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and
- a statement of Your right to bring suit under ERISA §502(a) (where applicable).

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health Plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the Plan for prescribing a length of stay up to 48 hours (or 96 hours).

ERISA Rights. An Account Plan that reimburses the Participant for medical services is subject to the Employee Retirement Income Security Act of 1974 (ERISA). An Account Plan that reimburses only medical premium is not subject to ERISA. Some of Your basic rights under ERISA are described below. Your rights under ERISA and other federal and state law as related to other Qualified Benefit Plans You elected are fully detailed in the Summary Plan Descriptions that are maintained by Your Employer for those Plans.

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration [sic Employee Benefits Security Administration].
Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health Plan, if You have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health Plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Participants and

beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a (pension, welfare) benefit or exercising Your rights under ERISA.

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

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

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

Appendix D: Notice of HIPAA Privacy Practices

San Francisco Symphony Health and Welfare Plan

PRIVACY PRACTICES NOTICE

(Version 02/16/2026)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: San Francisco, CA______________________________

Telephone: (415) 864-6000______________

Address: Davies Symphony Hall 201 Van Ness Ave. San Francisco, CA 94102______________

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Medical PPO, EPO, HDHP

Health Reimbursement Account

Healthcare FSA

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **{insert date, e.g., February 16, 2026}**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality

assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes and substance use disorder counseling notes we hold only with your authorization.

If we receive substance use disorder treatment records created by a federally assisted program or health care provider under 42 CFR Part 2, we may only use or disclose such records in accordance with the written consent you provided to the program or provider. If such records were disclosed to us with your written consent for treatment, payment, and health care operations, we may further disclose the records for these purposes without obtaining an additional written consent.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer : We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;

- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Prohibited Uses and Disclosures: If we receive substance use disorder records created by a federally assisted program or health care provider under 42 CFR Part 2, we may not use or disclose such records, or testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceedings against you unless based on your specific written consent or a court order. We may only use or disclose records based on a court order after:

1. a notice and an opportunity to be heard is provided to you or the holder of the record, where required by 42 CFR part 2; and

2. the court order is accompanied by a subpoena or other similar legal requirement compelling the disclosure.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care

operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, ____

[name of claimant]

hereby appoint____ to act on my behalf

[name of Authorized Representative]

or on behalf of____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

□ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

____ _______________

Claimant's signature Date

Accepted:_____________________________________ _______________

Authorized Representative's signature Date

Witness:______________________________________ _______________

Witness signature Date

Appendix D: Summary of Material Modifications 2026

Summary of Material Modifications
Prepared for San Francisco Symphony Participants
Effective January 1, 2026

To: Employee participants in the San Francisco Symphony Health and Welfare Plan, and COBRA participants

From: Attention: Benefits Manager, SF Symphony
201 Van Ness Ave
San Francisco, CA 94102
(415) 503-5318

Date: January 01, 2026

The San Francisco Symphony Health and Welfare Plan sponsored by San Francisco Symphony has been revised. The changes summarized below are effective January 1, 2026.

1. 2026 IRS contribution limits:
   - Healthcare FSA: $3,400 with $680 carry-over maximum
   - HSA: $4,400 self-only / $8,750 family; catch up for ages 55+ will remain $1,000
   - Parking/Transit: $340 / $340

2. Some medical contribution costs have been adjusted for 2026

Please contact me, the Benefits Manager (acting on behalf of the plan administrator, San Francisco Symphony), if you have questions regarding the information in this SMM. I can be reached as follows:

Phone: (415) 503-5318

Address: 201 Van Ness Ave San Francisco, CA 94102

FILING INSTRUCTIONS
Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION
Plan Sponsor: San Francisco Symphony

Sponsor's EIN#: 94-1156284

Plan Name: San Francisco Symphony Health and Welfare Plan

Plan Number: 501

Plan Year: January 1 to December 31, 2026

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