ANNUAL EMPLOYER NOTICES

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Authority Brands, Inc.

2022 - 2023 Annual Employer Notices

Health Care Reform

The new federal health reform law focuses on establishing new state- based mechanisms for obtaining coverage and for establishing federal standards to oversee benefit designs and costs of coverage. Most of the significant reforms, including Exchanges and guarantee issue requirements, became effective in 2014. Other less significant reforms have already been implemented with the 2011, 2012 and 2013 plan years. Some of the changes to health plan benefits include the elimination of pre-existing conditions, no life-time limits or annual limits on certain plan benefits. Recently, the government removed the requirement of the individual mandate. In other words, individuals are not required to purchase health insurance for 2019 and beyond and will not be subject to a potential penalty if health insurance is not purchased.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") deals primarily with how Authority Brands, Inc. can enforce eligibility and enrollment for health care benefits. Examples of some of the HIPAA requirements include:

- Special enrollment periods are available during the year to you and your eligible dependents (in certain circumstances) that lose other health care coverage if you enroll within 31 days after losing the other health care coverage.
- If you are not enrolled for health care coverage and add an eligible dependent (i.e. marriage), you can enroll yourself and your other eligible dependents within 31 days of the event. If you add an eligible dependent (i.e. birth, adoption or placement for adoption), you can enroll yourself and your newly acquired eligible dependents within 31 days of the event.

The Plan will not base eligibility rules or waiting periods on any of the following factors: health status, mental or physical medical condition, and genetic information, evidence of insurability or disability. Evidence of insurability will not be required when health care coverage is requested during a special enrollment period or during an annual enrollment. However, the Plan may continue to provide for the exclusion of specified health conditions and apply lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

Changing Your Elections

In general, your annual pre-tax benefit elections are irrevocable for the plan year, July 1, 2022 through June 30, 2023. However, if you experience a Change in Status or special enrollment event that directly affects your eligibility for coverage; you may change your election within 31 days of the event. Under limited circumstances, an election change based solely on a Change in Status must be consistent with your Change in Status (i.e. if a child is born to you, you add coverage for that child).

In general:

Change in Status events provide more opportunities for you to make an election change than do special enrollment rights.

If your event could be considered both a Change in Status event and a special enrollment right, you may make any change allowed by either a Change in Status or special enrollment right.

Contact the Authority Brands, Inc. Benefits Department at 800-496-9019, for more information on the requirements for making an election change based on a Change in Status event or special enrollment right.

<u>Change in Status Events that Permit Election Changes for Health Benefits and Life Insurance Benefits:</u>

- Change in marital status: you may elect coverage for yourself and/or your newly acquired spouse or drop coverage for your spouse if you divorce, legally separate, have your marriage annulled or your spouse dies.
- Change in your number of dependents: you may elect coverage for your newborn, adopted child or a child placed with you for adoption. You may drop coverage if a dependent child dies.
- Change in employment status: you may add or drop coverage consistent with a change in employment status of you, your spouse or dependents that affect the benefit eligibility under this plan or under the employee benefit plan of your spouse or dependents. You, your spouse or dependent experience a change in employment status when any of the following occur and benefit eligibility is affected: begin or end employment, take part in a strike or lockout, begin or return from an approved leave of absence, switch from hourly to salaried, switch from union to non-union or vice versa, reduce or increase the number of hours you work or any similar change that affects your eligibility under the plan.
- Dependent eligibility: you may add or drop your child in the event he or she becomes or ceases to be eligible under the plan.
- Change in residence: you may change your coverage option if you move and it significantly affects your benefit availability.

<u>Additional Change in Status Events that Permit Election Changes for Health Benefits Only:</u>

- Family and Medical Leave Act (FMLA) – certain election changes are permitted when you start an FMLA leave or when you return from an FMLA leave.
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a "qualified medical child support order" or QMCSO) that requires health coverage for an Associate's child or foster child.
- You, your spouse or your dependent become entitled to or lose eligibility for Medicare or Medicaid.
- You, your spouse or your dependent gain eligibility under another employer's plan.
- A significant change in your cost for health coverage.
- A Change in Status that results in a "special enrollment right" under the Health Insurance Portability and Accountability Act (HIPAA). Please refer to the section below for more information.

You must complete a Change Form and return it to the Authority Brands, Inc. Benefits Department within 31 days of the Change in Status. If you miss this 31-day period, you will not be able to change your coverage until the following Annual Enrollment period, unless you have another Change in Status that affects your eligibility under the plan.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in a group health plan at times other than initial eligibility or the Annual Enrollment period. You have special enrollment rights if you and/or your eligible dependents lose other group health coverage, or you gain a new dependent. If either of these events occurs, you must enroll within the 31-day time limit explained here, or you will lose your special enrollment rights for that event.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the medical and/or dental plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of eligibility does not include a loss of coverage that occurs because you fail to pay premiums on a timely basis, if your other coverage is terminated for cause or your voluntary termination of COBRA continuation coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

You must request enrollment in the medical and/or dental plan no later than 31 days after the event giving rise to your special enrollment right, by completing and returning a new Benefit Enrollment and Change Form. If you fail to request enrollment within the 31-day time period, you and your dependents will lose the special enrollment rights for that event.

If your special enrollment right occurs because you lost other coverage or married, your enrollment is effective on the first day of the month after your Benefits Department receives your properly completed Change Form. If your special enrollment right occurs because of a new dependent child, coverage is effective on the date of the birth, adoption or placement for adoption.

If you or your dependent is eligible, but not enrolled, for health coverage under the Authority Brands, Inc. medical plan, you and/or your dependent may enroll in the plan if (i) your Medicaid or CHIP coverage is terminated as a result of loss of eligibility or (ii) you and/or your dependent become eligible for premium assistance under Medicaid or CHIP. However, to be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date you and/or your dependent become eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends. For more information on Medicaid and CHIP, please see the section below entitled Medicaid/CHIP.

To request enrollment due to a special enrollment right or obtain more information, contact the Authority Brands, Inc. Benefits Department at 800-496-9019.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or

www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15th, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com / Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.as px **Phone: 1-855-459-6328** **Email: KIHIPP.PROGRAM@ky.gov KCHIP Website:** **https://kidshealth.ky.gov/Pages/index.as px Phone: 1-877-524-4718** **Kentucky Medicaid Website: https://chfs.ky.gov**	**Medicaid Website:** **http://dhcfp.nv.gov Medicaid Phone:** **1-800-992-0900**
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservice s/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid / Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**

Website: **http://dss.sd.gov** **Phone: 1-888-828-0059**	**Website:** **https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm** **Phone: 1-800-362-3002**
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act (FMLA), you may be eligible for up to 12 weeks of unpaid leave for certain family and medical reasons and continue your benefits at active employee rates. You are eligible for FMLA leave if you have been employed by Authority Brands, Inc. for at least one year and worked at least 1,250 hours over the previous 12 months.

You may be eligible to take FMLA leave:

- After the birth or adoption of your child or if a child is placed with you for adoption
- To care for your spouse, child or parent who has a serious health condition (including medical conditions resulting from military service)
- If you have a serious health condition that makes you unable to perform your job

You may choose to either continue benefits on the same basis as if you continued working (were an active employee) or revoke your health benefit election (i.e. cancel your benefits) while you are on FMLA leave. If you revoke your benefit election while on FMLA leave, your election can be reinstated when you return to work. If you continue your benefits while on FMLA leave, you must pay your share of the cost for your benefits coverage during your period of FMLA leave. If your leave is unpaid (or paid and does not cover the entire cost), you are responsible for paying your portion of the premiums directly to the insurer. If you fail to make a premium payment, your coverage will be terminated. If your coverage terminates while you are on FMLA leave, your coverage can resume when you return from your FMLA leave of absence. For more information about FMLA leave and your benefit coverage while on FMLA leave, please contact Authority Brands, Inc. Benefits Department.

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

The Authority Brands, Inc. medical plan complies with the Mental Health Parity Act of 1996 (“MHPA”). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

MHPA and MHPAEA only apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. Take out if not applicable.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Authority Brands, Inc. medical plan will comply with all required provisions of the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA) with respect to health benefits provided under this plan. The plan will not 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. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the plan will not require that a provider obtain authorization from the plan and insurer for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother’s or newborn’s attending

provider, after consulting with and obtaining consent from the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act (WHCRA)

The Authority Brands, Inc. medical plan complies with all required provisions of the Women's Health and Cancer Rights Act of 1998 (WHCRA) with respect to health benefits provided under this plan. The plan will cover certain breast reconstruction and other benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for (1) all stages of reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, (3) prosthesis and (4) treatment of physical complications for all stages of mastectomy, including lymphedemas. Such coverage remains subject to the terms of the Plan, including normal deductible, copay and coinsurance provisions.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Authority Brands, Inc. medical plan will comply with all required provisions of GINA with respect to health benefits and coverage under this plan. The plan will not discriminate on the basis of genetic information, including information about manifestation of a disease or disorder in a family, in addition to information about genetic tests. Furthermore, genetic information will not be requested or required for underwriting purposes or before enrollment, participants and covered dependents will not be required to undergo genetic testing and genetic information will not be used to adjust premiums or contributions for groups under the Authority Brands, Inc. medical plan. However, the plan and/or employer may use, in accordance with GINA, a minimum necessary amount of genetic testing results in order to make a determination about a claim payment where such information is necessary and/or required. For more information about GINA, please contact your Benefits Department.

Michelle's Law

Subject to future regulations and the Affordable Care Act, the Authority Brands, Inc. medical plan will comply with all required provisions of Michelle's Law with respect to health benefits provided under this plan to dependent children over the age of 18 who are enrolled in an institution of higher education on a full-time basis. If the dependent child is enrolled on a full-time basis and subsequently loses his/her full-time status at his/her institution of higher education as a result of taking a "medically necessary leave of absence" (as defined under Michelle's Law) due to a serious illness or injury, coverage for the dependent under the Authority Brands, Inc. medical plan will not terminate until the earlier of (i) the date that is one year after the first day of the medically necessary leave of absence or (ii) the date coverage would otherwise terminate under the plan. The student/dependent on leave is entitled to the same benefits as if he/she had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Please note that under the Affordable Care Act, group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply. For more information about Michelle's Law and your dependent's benefit coverage under Michelle's Law, please contact the Authority Brands, Inc. Benefits Department.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Important Information about Your Right to COBRA Continuation Coverage

This contains important information about your right to group health plan continuation coverage, which is a temporary extension of coverage under the Plan after you (and/or your qualified dependent) would otherwise lose group health coverage under the Plan. The right to this continuation coverage (COBRA continuation coverage) was created by Federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may elect to temporarily continue your group health coverage for yourself and any eligible dependents covered by the Authority Brands, Inc. group health plans on the day your (or your qualified dependents) group health benefits ceased because of a qualifying event. You and your eligible dependents are eligible to elect COBRA continuation coverage even if you (or they) have health coverage under another group health plan. Please read this section carefully as it generally explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you (and they) need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefits Department.

Eligibility for COBRA Continuation Coverage

COBRA continuation coverage is continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each plan participant who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if group health coverage under the plan is lost

because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

Qualifying Events and COBRA Continuation Coverage

The qualifying events for COBRA continuation coverage and the maximum COBRA continuation coverage periods are shown in the charts that follow.

Employee COBRA Continuation Coverage

If you are an employee of Authority Brands, Inc. and are covered by Authority Brands, Inc.'s health plan you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
Termination of your employment (for reasons other than gross misconduct)	18 months
Reduction in your hours of employment with loss of eligibility for benefits	18 months

Spouse of an Employee COBRA Continuation Coverage

If you are the spouse of an employee of Authority Brands, Inc. and are covered by Authority Brands, Inc.'s health plan, you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
Divorce or legal separation from the employee	36 months
The employee's entitlement to Medicare	36 months

Dependent Children of an Employee COBRA Continuation Coverage

Dependent children of an employee of Authority Brands, Inc. who are covered by Authority Brands, Inc.'s health plan have the right to COBRA continuation coverage (for the period stated) if they lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
The employee's divorce or legal separation	36 months
The employee's entitlement to Medicare	36 months
Loss of eligible dependent status (i.e., reach maximum age, lose full-time student status)	36 months

The maximum period of COBRA continuation coverage is measured from the date of the loss of coverage due to the applicable qualifying event specified above.

The plan will offer COBRA continuation coverage to a qualified beneficiary only after the Authority Brands, Inc. Benefits Department has been properly notified that a qualifying event has occurred.

You must notify the Authority Brands, Inc. Benefits Department within sixty (60) days of the following qualifying events: divorce or legal separation of the employee; spouse or a dependent child losing eligibility for coverage as a dependent under the plan, or Medicare entitlement. You must provide this notice to the Authority Brands, Inc. Benefits Department within the sixty (60) day deadline or your right to COBRA continuation coverage will be lost and will not be reinstated. Notice requirements are detailed below.

A special rule applies if you drop coverage for your spouse and/or eligible dependent children because you are planning to divorce. In such a case, your spouse and/or dependent children who had previously been covered under the plan would be entitled to elect COBRA continuation coverage for up to thirty-six (36) months from the date the divorce is final, but only if the Authority Brands, Inc. Benefits Department is notified of the divorce within sixty (60) days from the date of final judgment. No retroactive coverage before the date of divorce is available.

If it is determined that an individual is not eligible for COBRA continuation coverage, the Authority Brands, Inc. Benefits Department will notify such individual of his or her failure to qualify for COBRA continuation coverage. This notice will explain why the individual is not entitled to COBRA continuation coverage and will be sent within fourteen (14) days after the receipt of the individual's notice of a qualifying event.

Subsequent Qualifying Event

If a subsequent qualifying event that is not your termination of employment or reduction in work hours (such as your divorce, legal separation, your death or your dependent child ceasing to be eligible under the plan) occurs during an initial eighteen (18) month period of coverage, COBRA continuation coverage may be extended for your eligible dependents who are qualified beneficiaries for up to a maximum period of thirty-six (36) months measured from the date of the first qualifying event. An event shall not be a subsequent qualifying event unless that event would cause a loss of coverage under the Plan independent of the initial qualifying event. The covered employee will not be eligible for an extension of your maximum 18-month period of COBRA continuation coverage for a subsequent qualifying event.

Notice of a subsequent qualifying event must be given to the Authority Brands, Inc. Benefits Department within a maximum of sixty (60) days in order to extend COBRA continuation coverage. If you fail to inform the Authority Brands, Inc. Benefits Department, you will lose your right to extend your COBRA continuation coverage and this right will not be reinstated. Notice requirements are detailed below. Please see the special COBRA continuation coverage for Disabled Persons section of this guide for information on disability as a subsequent qualifying event.

Notice Requirements

In most cases, the Authority Brands, Inc. Benefits Department (or such other assigned individual, entity, or department) will notify you of your right to elect COBRA continuation coverage. However, if your eligible dependent has a qualifying event as a result of your divorce, legal separation, Medicare entitlement or lose their status as a dependent, you or your covered dependent must properly notify the Authority Brands, Inc. Benefits Department within a maximum of sixty (60) days of the qualifying event. In addition, if you have a child born, legally adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the Authority Brands, Inc. Benefits Department within sixty (60) days of the event in order to cover the child.

Notice must be submitted to the Authority Brands, Inc. Benefits Department at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046 on the written form approved by the Benefits Department. The form must be completed and submitted to the Authority Brands, Inc. Benefits Department before the end of the applicable deadline. The forms, information and deadlines for certain events are outlined in the table below.

Event Requiring Notice	**Deadline for Notice**
Divorce or Legal Separation	Within 60 days from date of final court judgment
Dependent becomes ineligible under the plan	Within 60 days from date of ineligibility
Medicare entitlement	Within 60 days from date of entitlement
Determination of disability	Within 60 days of disability determination and before the end of the maximum 18-month COBRA continuation coverage period
Determination of non-disability status	Within 30 days of the Social Security Administration's determination of non-disability
Marriage	Within 31 days from the date of marriage
Birth, Adoption or Placement for Adoption	Within 60 days from date of the event

Failure to properly provide the required notice may result in loss of any COBRA continuation right and, if lost, this right will not be reinstated.

The Authority Brands, Inc. Benefits Department is the designated recipient for all COBRA continuation coverage notices. They may be reached at: 800-496-9019, 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046.

Electing COBRA Continuation Coverage

Once the Authority Brands, Inc. Benefits Department receives notice that a qualifying event has occurred, COBRA continuation coverage will then be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, you may elect COBRA continuation coverage on behalf of your spouse and parents may elect COBRA continuation coverage on behalf of their children.

If you wish to elect COBRA continuation coverage, you must notify the Authority Brands, Inc. Benefits Department within a maximum of sixty (60) days of the later of: (i) the date of the qualifying event or (ii) the date you received your COBRA notice. If you choose to continue benefits for yourself and your eligible dependent, before the maximum sixty (60) day election deadline, your coverage will continue uninterrupted. If you (or your eligible dependent) fail to elect COBRA continuation coverage within the maximum sixty (60) days after you are notified by Authority Brands, Inc., you will lose your right to COBRA continuation coverage and that right will not be reinstated.

You must also keep Authority Brands, Inc. Benefits Department informed of all the information needed to meet its obligation of both providing notice to you of your right to COBRA continuation coverage and providing the actual COBRA continuation coverage. Such information includes your current contact information and administrative information about yourself, your spouse and/or dependents. You or your spouse's election to take COBRA continuation coverage can also be an election to cover all the other qualified beneficiaries in the family, unless the election is specific as to which qualified beneficiaries are to be covered.

You must notify the Authority Brands, Inc. Benefits Department to request alternate coverage if you move outside the service area of the benefit network for your elected coverage. Alternate coverage will be made available (if available) to you not later than the date of the relocation or the first day of the month following the month in which the request is made.

Health Care Exchange - Notice

There may be other coverage options for you and your family. For example, you will be able to buy coverage through the Health Insurance Marketplace during the Marketplace's open enrollment period. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Special Enrollment Events and COBRA

If you have a child born to, adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the Authority Brands, Inc. Benefits Department and elect coverage within sixty (60) days of the child's birth, adoption or placement for adoption. If you get married during your COBRA continuation coverage, you may add your new spouse to your COBRA continuation coverage if you notify the Authority Brands, Inc. Benefits Department within thirty-one (31) days of the date of the marriage. A new dependent may be a participant under this coverage for the remainder of your maximum COBRA continuation period (eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the applicable qualifying event).

Cost and Payment of COBRA Premiums

You must pay the full cost for COBRA continuation coverage (plus a two percent (2%) administrative fee). Authority Brands, Inc. will determine this cost, but it generally cannot exceed one hundred two percent (102%) of the plan's cost for providing coverage to similar situated covered active employees and their covered dependents. COBRA premiums are subject to change annually. If you and your covered dependents are receiving an additional eleven (11) months of COBRA continuation coverage due to disability as the qualifying event, Authority Brands, Inc. will determine COBRA premium which will not exceed one hundred fifty percent (150%) of the plan's cost for providing coverage, if the disabled qualified beneficiary is part of the COBRA continuation coverage group or one hundred two percent (102%) if the disabled qualified beneficiary is not receiving COBRA continuation coverage.

Once an election for COBRA continuation coverage is made, you (or your covered dependents) have a maximum of forty-five (45) days from the date of election to pay the premium for the current month and any retroactive COBRA premiums then due for the elected coverage. Although coverage is retroactive to the date of loss of coverage due to the initial qualifying event, no COBRA continuation coverage benefits will be paid until this first COBRA premium is received by Authority Brands, Inc.. If payment is not received within the forty-five (45) day period, then coverage will either be revoked retroactively or not become effective. You will lose your right to COBRA continuation coverage and it will not be reinstated.

All subsequent COBRA premium payments are due on the first day of the month. The plan allows a thirty (30) day grace period for payment of required COBRA premiums (except the first payment previously discussed). Even if you do not receive a bill, you must still submit your COBRA premium payments within the required time period. ***The thirty (30) day grace period does not apply to the forty-five (45) day period for payment of the initial COBRA premium.*** If your COBRA premium payment is not postmarked by the last day of the grace period, your COBRA continuation coverage will end as of the last day of the last month for which a full COBRA premium payment was made.

If timely payment of the COBRA premium is made to the plan in an amount that is not more than fifty dollars ($50) or ten percent (10%) less than the required COBRA premium payment, then the amount paid is deemed to satisfy the plan's requirement for full COBRA premium payment, unless Authority Brands, Inc. notifies the qualified beneficiary of the amount of the deficiency and allows thirty (30) days for payment of the deficiency to be made.

COBRA premiums can be paid by you or by a third party on your behalf. Here are a few other details about COBRA premium payments you need to be aware of:

- No late or reminder notices will be sent for payments that have not been made.
- Once COBRA continuation coverage is terminated, it cannot be reinstated.
- All terms and conditions that apply to active participants in the plan are also applicable to COBRA continuation coverage participants.
- All rules and procedures for filing and determining benefit claims and appeals under the plan that apply to active employees also apply to COBRA continuation coverage.

Trade Act Credit

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PGBC) (eligible individuals) and pay for health coverage. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Responses to Information Regarding a Qualified Beneficiary's Right to Coverage

Upon request, the plan must inform health care providers regarding the qualified beneficiary's right to coverage during the applicable grace periods. In addition, the plan is required to respond to inquiries from health care providers regarding the qualified beneficiary's right to coverage during the election period and his or her right to retroactive coverage if COBRA continuation coverage is elected.

Changes in Benefits under COBRA

If you or any covered dependents elect COBRA continuation coverage, benefits will be the same as were in effect at the time of your qualifying event. You will be able to change your plan coverage option during annual enrollment to the same extent as similarly situated active employees. If the group health plan benefits of active employees change, benefits for qualified beneficiaries on COBRA continuation coverage will also change in the same manner.

Special COBRA Continuation Coverage for Disabled Persons

If you (and your covered dependents) are receiving eighteen (18) months of COBRA continuation coverage and your qualifying event is a termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by eleven (11) months to up to a maximum of twenty-nine (29) months in total provided the following requirements are met:

- The Social Security Administration determines that you (or your dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability exists as of the date of the qualifying event or at any time during the first sixty (60) days of COBRA continuation coverage following the qualifying event; and
- The disability lasts at least until the end of the eighteen (18) month period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to Authority Brands, Inc. within the initial eighteen (18) month coverage period and within sixty (60) days after the latest of: (1) the date of the Social Security Administration determination of disability; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the notice of disability. If you fail to properly notify Authority Brands, Inc. within the deadline above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated. Please refer to the Notice Requirements section above for information about proper notice to the plan.

If the Social Security Administration determines later that the qualified beneficiary is no longer disabled, Authority Brands, Inc. must be properly notified within thirty (30) days of the Social Security Administration’s determination. This notice will end the extended COBRA continuation coverage for all qualified beneficiaries within the coverage group. Failure to notify Authority Brands, Inc. that a qualified beneficiary is no longer disabled will result in termination of COBRA continuation coverage for all qualified beneficiaries within the coverage group effective on the date of the Social Security Administration determination and such coverage will not be reinstated. When the disabled qualified beneficiary becomes eligible for Medicare, Authority Brands, Inc. must be properly notified to end the extended coverage for the affected disabled qualified beneficiary. Please refer to the Notice section above for information about proper notice to the plan.

COBRA Continuation Coverage and Medicare

If your dependent is receiving COBRA continuation coverage and you become entitled to Medicare benefits, your coverage will end but COBRA continuation coverage for your qualified dependents may continue for up to thirty-six (36) months measured from the date of the initial qualifying event.

In addition, if you become entitled to Medicare and then later terminate employment (for reasons other than gross misconduct) or have a reduction in hours, your qualified dependents who are eligible for COBRA continuation coverage will be eligible for thirty-six (36) months of COBRA continuation coverage measured from the date you became entitled to Medicare. However, you will only be eligible for eighteen (18) months of COBRA continuation coverage measured from the qualifying event.

Termination of COBRA Continuation Coverage

COBRA continuation coverage shall not be provided beyond the earliest of the following dates:

- The date the maximum COBRA continuation coverage period expires based upon the qualifying event;
- The date the plan is terminated, and no other group health plan is provided to active employees;

- The last day of the month preceding the month for which the qualified beneficiary fails to pay the premium for COBRA continuation coverage by the last day of the grace period;
- The date the qualified beneficiary first becomes entitled to Medicare, including Medicare entitlement due to End Stage Renal Disease (ESRD), after the person elects COBRA continuation coverage;
- The date that initial payment is not received within a maximum of forty-five (45) days after the election of COBRA continuation coverage is made;
- The date the qualified beneficiary first becomes covered under another group health plan or policy after the date the person elects COBRA continuation coverage; or
- For a disabled qualified beneficiary receiving COBRA continuation coverage during the eleven (11) month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination shall end COBRA continuation coverage for all qualified beneficiaries as of the later of either: (a) the first day of the month following thirty (30) days from the final determination date; or (b) the end of the COBRA continuation coverage period based on the initial qualifying event without regard to a disability extension.

If your COBRA continuation coverage is terminated for any of the reasons noted above, your coverage will end and will not be reinstated.

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, Authority Brands, Inc. will notify you of the termination of your coverage as soon as administratively possible. This notice will explain why and when COBRA continuation coverage has ended.

Contact Information for COBRA Administrator

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.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Authority Brands, Inc. Benefits Department informed of any changes in the address of family members. You should also keep a copy of all COBRA notices that you receive or send in your own records.

Plan Contact Information

Information about the plan may be obtained by contacting the Authority Brands, Inc. Benefits Department at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046.

Notice of Privacy Practices

This Notice is for Authority Brands, Inc. employees/retirees (and their dependents) participating in the Company health plans (medical, dental, vision, life & disability, FSA, and HSA), which together have been designated as the Company Healthcare Arrangement (the "Plan"). If you are not currently participating in these plans, but begin participating in the future, this Notice will apply to you once you begin participating.

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.

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan is required to:

- take reasonable steps to ensure the privacy of your personally identifiable health information;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you (the participant); and
- follow the terms of this Notice.

In addition to the requirements above, this Notice is intended to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

If you have any questions about this Notice, please contact the Privacy Officer at Authority Brands, Inc.. The contact information for the Privacy Officer is as follows:

Privacy Officer

Authority Brands, Inc.

7120 Samuel Morse Dr.

Suite 300, Columbia, MD, 21046

Who Will Follow This Notice

This Notice describes the health information practices of the Plan, and that of third parties that provides services to the Plan. All references to “you” include employee/retiree participants and their dependent(s) who participate in the Plan.

Our Pledge Regarding Medical Information

The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. The Plan creates a record of the health care claims reimbursed under the Plan for Plan administration purposes. This Notice applies to all of the health records that the Plan maintains. Your personal doctor or health care provider may have different policies or Notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office or clinic.

The Plan will not use or disclose your PHI that is genetic information about you for underwriting purposes.

This Notice will tell you about the ways in which the Plan may use and disclose medical information about you. It also describes the Plan’s obligations and your rights regarding the use and disclosure of medical information.

Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

Uses and Disclosures to carry out Treatment, Payment and Health Care Operations

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the Plan Sponsor, Authority Brands, Inc., for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization) for the health care services you receive. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Furthermore, the Plan may, for payment purposes, take actions to make coverage determinations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Other examples include the Plan using your health information to review the performance of our staff and vendors. The Plan may also use your information and the information of other members to plan what services the Plan needs to provide, expand, or reduce. The Plan may disclose your health information as necessary to others who the Plan contracts with to

provide administrative service, which includes the Plan's lawyers, auditors, accreditation services, and consultants, for instance.

Uses and Disclosures that Require Your Written Authorization

Your express written authorization must be received before the Plan sells any PHI about you. Also, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

In addition, your written authorization is required for any marketing communication which includes a communication about a product or service that encourages you to buy or sue the product or service being marketed. However, if there is no direct or indirect fee to the Plan, an authorization is not required. Moreover, communications the Plan makes about its own health care products or services, communications for treatment purposes, and communications for purposes of case management or Personal Health Support or to recommend alternative treatments, therapies, providers or settings of care are accepted from the authorization requirement.

Use and Disclosures that Require that you be given an Opportunity to Agree or Disagree Prior to the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for which Consent, Authorization or Opportunity to Object is not Required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

To Avert a Serious Threat to Health or Safety. The Plan may disclose your health information if the Plan decides that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs.

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement;

- about a death the Plan believes may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The plan may also release medical information about patients of a hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institutions.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could ask that the Plan not use or disclose information about a surgery you had.

The Plan is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. To request restrictions, you must make your request in writing to the Privacy Officer, c/o Authority Brands, Inc., at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Inspect and Copy PHI

You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. You also have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

To inspect and copy medical information that may be used to make decisions about you or to inspect and copy a designated record set, you must submit your request in writing to the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set or by the Plan.

To request an amendment, your request must be made in writing and submitted to: Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. In addition, you must provide a reason that supports your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that:

- is not part of the medial information kept by or for the Plan;

- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To request an accounting of disclosures, your request must be made in writing and submitted to the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. In addition, you must provide a reason that supports your request and in what form you want the list (for example, paper or electronic).

The Right to Request Confidential Communications

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046.

The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

The Right to Receive a Paper Copy of This Notice Upon Request

You have a right to receive a paper copy of this Notice even if you have previously received a copy or agreed to receive this Notice electronically.

You may also obtain a copy of this Notice on the intranet.

To obtain a paper copy of this Notice, please contact the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046.

The Right to Opt-Out of Receiving Fundraising Communications

You may opt-out of receiving fundraising communications from the Plan by contacting the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties

The Duty to Notify in Case of a Breach

The Plan is required by law to notify any affected individuals of a breach of unsecured PHI.

The Plan’s Rights and Responsibilities to Change This Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with Notice of its legal duties and privacy practices.

This Notice is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change their privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI. You will receive a copy of any revised Notice from the Plan by mail or by e-mail, but only if e-mail delivery is offered by the Plan and you agree to such delivery.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures required for the Plan's compliance with legal regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose "summary health information" to Authority Brands, Inc. for obtaining premium bids or modifying, amending or terminating the Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Authority Brands, Inc. has provided health benefits under the Plan; and from which identifying information has been deleted in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Privacy Officer, c/o Authority Brands, Inc. at 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Authority Brands, Inc. Benefits Department at 800-496-9019, who can put you in contact with the Privacy Officer at Authority Brands, Inc., 7120 Samuel Morse Dr. Suite 300, Columbia, MD, 21046. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

Important Notice from Authority Brands, Inc. 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 Authority Brands, Inc. 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.Authority Brands, Inc. has determined that the prescription drug coverage offered by the Authority Brands, Inc. medical plan(s) 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 current Authority Brands, Inc. coverage may be affected.

$1,000 PPO: $15/$40/$75 copay

$2,000 QHDP: 20% after the deductible

$4,000 PPO: $15/$40/$75 copay

If you do decide to join a Medicare drug plan and drop your current Authority Brands, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Authority Brands, Inc. and do not 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 Authority Brands, Inc.'s Benefits Department at 800-496-9019 for further information. NOTE: You will 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 Authority Brands, Inc. changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011 - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 will 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 www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

Authority Brands, Inc.
Position/Office: Benefits Department
7120 Samuel Morse Dr.
Suite 300, Columbia, MD, 21046
800-496-9019

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October prior to the year in which coverage is to begin. For 2022, that would be October 2021 for coverage effective 1/1/2022.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% of your household income for the year or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer – offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Authority Brands, Inc.'s Benefits Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Employee Eligibility—Look-Back Measurement Method

The Authority Brands, Inc. offers coverage under its Plan to full-time employees. A full-time employee is an employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month. Full-time employees may also elect coverage for their dependent children up to age 26 and eligible spouse or domestic partner as defined by the Plan.

Authority Brands, Inc. will use a look-back measurement method to determine whether an employee is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Authority Brands, Inc. employees working on an as needed basis. If you are a new non-seasonal employee who is expected to work full time, Authority Brands, Inc. will determine your status as a full-time employee who is eligible for Plan coverage based on your hours of service for each calendar month

The look-back measurement method involves three different periods:

- A **measurement period** for counting an employee's hours of service (also called a standard measurement period or an initial measurement period);
- A **stability period** when the employee is either treated as full-time or non-full time for Plan eligibility purposes; and
- An **administrative period** that allows time for Plan enrollment and disenrollment.

Authority Brands, Inc. establishes how long these periods will last, subject to specified IRS parameters.

The rules for the look-back measurement method are complex. They vary depending on whether an employee is an ongoing employee or a new employee, and whether a new employee is expected to work full time or is a variable, seasonal or part-time employee. Authority Brands, Inc. intends to follow the IRS final regulations (including any subsequent guidance issued by the IRS on the look-back measurement method) when administering the look-back measurement method.

Ongoing Employees

For ongoing employees, Authority Brands, Inc. determines full-time status by looking at a **standard measurement period (SMP)** lasting 12 consecutive months. The SMP starts on date of hire and ends on the last day of the 12th month after the date of hire. An employee's hours of service during the SMP will determine his or her Plan eligibility for the stability period that follows the SMP.

An ongoing employee is one who has been employed by Authority Brands, Inc. for at least one complete SMP.

If an ongoing employee was employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is treated as a full-time employee for a set period into the future, known as the **stability period**. This means that, as a general rule, the employee is eligible for Plan coverage during the stability period, regardless of the employee's number of hours of service during the stability period, as long as he or she remains an employee.

The final IRS regulations include an exception for certain employees who have been continuously offered Plan coverage and who transfer to part-time positions during the stability period. If certain conditions are met, Plan eligibility for these transferred employees may end during a stability period. Authority Brands, Inc. intends to follow applicable IRS guidance, including the rules for changes in employment status, when administering the look-back measurement method.

If an ongoing employee was not employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

The stability period may align with the SMP, and lasts for 12 consecutive months, beginning with the date of hire and ends of the last day of the 12th month after the date of hire. Please confirm with your HR representative.

Authority Brands, Inc. also uses an administrative period between the SMP and the stability period. The administrative period may last up to 90 days. Please confirm with your HR representative. The administrative period overlaps with the prior stability period to prevent any gaps in coverage for employees enrolled in coverage because of their full-time status during a prior measurement period.

New Employees Expected to Work Full Time

For a new employee who is not a seasonal employee and who Authority Brands, Inc. reasonably expects at his or her start date to be a full-time employee, Authority Brands, Inc. will determine the employee's status as a full-time employee based on the employee's hours of service for each calendar month.

If the employee's hours of service for the calendar month equal or exceed an average of 30 hours of service per week (or 130 hours per month), the employee is a full-time employee for that calendar month. Once the new employee becomes an ongoing employee (that is, he or she is employed for at least one complete SMP), the measurement rules for ongoing employees will apply.

New Variable Hour, Seasonal or Part-time Employees

Under the look-back measurement method, Authority Brands, Inc. determines whether new variable hour employees, new seasonal employees and new part-time employees are full-time employees by measuring their hours of service during an **initial measurement period (or IMP).**

- An employee is a **variable hour employee** if, at the employee's start date, Authority Brands, Inc. cannot determine whether the employee is reasonably expected to be employed, on average, at least 30 hours per week because the employee's hours are variable or otherwise uncertain.
- A **seasonal employee** is generally an employee who is hired into a position for which the customary annual employment is six months or less. Also, the period of employment for a seasonal employee should begin each calendar year in approximately the same part of the year, such as summer or winter.
- A **part-time employee** is a new employee who Authority Brands, Inc. reasonably expects to be employed, on average, less than 30 hours per week during the IMP,

Similar to the method for ongoing employees, the look-back measurement method for new variable hour, seasonal and part-time employees utilizes a stability period for when coverage may need to be provided, depending on the employee's hours of service during the IMP. An administrative period is also used to make eligibility determinations and notify and enroll employees.

The IMP may align with the SMP, and lasts for 12 consecutive months, beginning with the date of hire and ends of the last day of the 12th month after the date of hire. Please confirm with your HR representative.

If a new variable hour, seasonal or part-time employee was employed, on average, at least 30 hours of service per week (or 130 hours per month) during the IMP, the employee is treated as a full-time employee for a set period into the future, known as the stability period. This means that the employee is eligible for Plan coverage during the **stability period**, regardless of the employee's number of hours of service during the stability period, as long as he or she remains an employee.

If a new variable hour, seasonal or part-time employee was not employed, on average, at least 30 hours of service per week (or 130 hours per month) during the IMP, the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

The final IRS regulations contain special rules for a new variable hour, seasonal or part-time employee who, before the end of the IMP, changes employment to a position or status where if the employee had started employment in the new position or status, he or she would have reasonably been expected to be employed full time as a non-seasonal employee. Authority Brands, Inc. intends to follow applicable IRS guidance, including the special rules for changes in employment status, when administering the look-back measurement method.

The stability period may align with the SMP, and lasts for 12 consecutive months, beginning with the date of hire and ends of the last day of the 12th month after the date of hire. Please confirm with your HR representative.

Authority Brands, Inc. also uses an administrative period between the IMP and the stability period. The administrative period may last up to 90 days. Please confirm with your HR representative.

Once a new variable hour, seasonal or part-time employee has been employed for an entire standard measurement period, the employee will be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

Rehired Employees and Employees Returning from Unpaid Leave

The following rules apply to rehired employees and employees returning from unpaid leave:

- If an employee goes at least 13 consecutive weeks without an hour of service and then earns an hour of service, he or she is treated as a new employee for purposes of determining the employee's full-time status under the look-back measurement method. Authority Brands, Inc. will apply a rule of parity for periods of less than 13 weeks. Under the rule of parity, an employee is treated as a new employee if the period with no credited hours of service is at least four weeks long and is longer than the employee's period of employment immediately before the period with no credited hours of service.
- For an employee who is treated as a continuing employee, the measurement and stability periods that would have applied to the employee had he or she not experienced the break in service will continue to apply upon the employee's resumption of service.

In addition, a special averaging method applies when measurement periods include special unpaid leave (that is, leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) or jury duty leave). This method only applies to an employee who is treated as a continuing employee upon resuming services for the employer, and not to an employee who is treated as terminated and rehired. Under the averaging method, Authority Brands, Inc. will either:

- Determine the average hours of service per week for the employee during the measurement period, excluding the special unpaid leave period, and use that average as the average for the entire measurement period; or

Treat employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.