Plane Healthy Wellness Center & Pharmacy

Summary Plan Description

May, 2022

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Introduction

This Summary Plan Description (SPD) describes your right to use The Plane Healthy Wellness Center & Pharmacy (the "Center"), operated by Premise Health. Eligible employees and their dependents may use the Center to receive personal medical care and pharmacy services. Access to the Center is offered as a component of the Textron Non-Bargained Medical Plan and the Textron Bargained Medical Plan (each a "Textron Medical Plan" and collectively the "Plan" or the "Textron Medical Plan").

The information presented is not intended to be construed to create a contract between you and Textron Aviation ("Aviation") or any other Textron company. This SPD is not intended to create a contractual right to employment between you and Aviation or any other Textron company. All employment is "at will."

Aviation and Textron Inc. reserve the right to amend, modify, suspend, replace or terminate all of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.

Eligibility

Who Is Eligible to Use the Center

Subject to the exclusions described below (under "Who is Not Eligible to Use the Center"), you are eligible to use the Center if:

- You are an employee of Aviation or Textron Financial Corporation and located in Kansas.

- You are a dependent of an eligible employee (as described above). For this purpose, dependent means your spouse or another individual two (2) years of age or older, who is classified as an eligible dependent under the Textron Medical Plan, as in effect and amended from time to time.

Center health care providers (other than the pharmacy) do not accept Medicare, and in connection with this do not accept payment from Medicare enrollees who may receive Medicare reimbursement for Center non-pharmacy services. Accordingly, individuals who are enrolled in Medicare may not use non-pharmacy Center services unless they are enrolled in a Textron medical coverage option (*i.e.*, Surest, high deductible, or maximum deductible); for Medicare-eligible individuals covered by one of those options, the plan will pay the full charge for Center non-pharmacy services.

In all cases, **entry to the Center is subject to the Aviation Security Protocol**.

Your right (and your dependents' right(s)) to use the Center ends on the date that the Center is closed, your employment with all Textron companies ends, or you or your dependents no longer meet the eligibility requirements to use the Center described in this SPD.

If your right to use the Center would otherwise end, your coverage may be continued

under COBRA (to the extent applicable). For further information, see Exhibit A, ***Continuing Access to the Center Under COBRA***.

Aviation reserves the right to audit eligibility at any time. If you enroll a dependent in coverage under this plan, the company reserves the right to request supporting documentation to confirm eligibility of that dependent. If ineligible dependents are found covered under the plan, Aviation will immediately terminate their access to the Center and if applicable, recommend disciplinary action including termination of employment and collection of the full cost of services provided to the ineligible dependents.

Who Is Not Eligible to Use the Center

You are not eligible to participate in the Plan if:

- You are classified by Textron as an independent contractor, leased employee, temporary employee or other non-employee (even if you are later classified by Textron, the IRS or other government agency or a court as a common-law employee of a Textron company);
- Your basic compensation for services is not paid directly by a Textron company;
- You were retained by a Textron company under a contract that states that you are not eligible to participate in the Plan;
- You are a non-resident alien and you receive no earned income from any of the Textron entities that constitutes income from sources within the United States under the Internal Revenue Code;
- You are a self-employed individual, as defined in the Internal Revenue Code;
- You are a retiree or other former employee of a Textron company;
- You are an individual engaged as a consultant or advisor on a retainer or fee basis, as determined by the Plan Administrator; or
- You are a member of Textron's Board of Directors who is not otherwise eligible to participate in the Plan.

Also, the Center does not accept Medicare or Medicaid. If you are enrolled in Medicaid, you will not be able to use the Center. If you are enrolled in Medicare, you may not use the Center unless you are also enrolled in (and make contributions for) medical coverage under a Textron Medical Plan.

Center Benefits

The Center is a primary health clinic and pharmacy, independently operated by Premise Health physicians and pharmacy professionals, and staffed by Premise Health with some or all of the following personnel: physicians, nurse practitioners, registered nurses, licensed practical nurses, pharmacists, pharmacy technicians, physical therapists, counselors, medical assistants and administrative assistants. The Center's primary care services generally include preventive services, certain acute/urgent care, certain

disease management services, certain routine clinical laboratory services, certain pharmacy services targeted to a primary care patient population, and referrals for care that is not available at the Center, such as to specialists, emergency rooms, hospitals, and other outside medical facilities and services.

For example, as medically appropriate, you may receive primary care, such as:

- Examination, diagnosis, and treatment of acute minor illnesses and injury, for conditions including:
  - Community Acquired Pneumonia
  - Ear infections (Otitis Media)
  - Sinus infections (Sinusitis)
  - Nasal inflammation (Rhinitis)
  - Sore throat (Pharyngitis)
- Minor primary care surgical procedures, such as suturing
- Preventive health services, including annual wellness exams, basic screenings, certain vaccines and immunizations, and health management, wellness and chronic condition coaching
- Health risk consultations on primary prevention, lifestyle behavior risks (e.g., diet and nutrition, smoking cessation, hypercholesterolemia, weight management, and stress), compliance with treatment plans, medication adherence, and self-monitoring
- Physical therapy and behavioral health services
- Pharmacy services, including the dispensing of prescription medications targeted to the populations served by the Center
- Routine clinical laboratory services, including onsite laboratory specimen collection, lab work, and follow-up lab interpretation/monitoring
- Certain imaging services
- Referrals to local community specialists and health facilities

The Center also furnishes Aviation with certain services for occupational medicine and work-related injuries. These services are not furnished as part of the Plan benefit described in this SPD.

Center Costs

If you choose to use the Center to receive the medical care or pharmacy services that it offers, you will be charged the full cost of services at rates set by the Center. All or part of the Center charges that you incur may be covered by your health insurance, whether that is coverage under a Textron Medical Plan or another health plan that is not sponsored by Textron.

Costs for occupational health services and work-related injuries that are covered by workers compensation insurance are provided at no cost to you.

Claims Procedure

To make a claim for benefits about your right to use the Center, you must submit a claim as described in this section. **The claims procedure set forth in this SPD <u>applies only</u> to claims that are about your right to use the Center generally, and not to claims about your right to receive any particular medical or pharmacy service at the Center.** In order to make a claim about the medical care or pharmacy services that you receive at the Center (for example, the amount of coinsurance that you pay for a service received at the Center), you must follow the claims procedure of your health insurance plan and the claims procedure described in this SPD **<u>does not apply</u>**.

Claims Filing Deadline

You must submit all claims for benefits within one (1) year of the date of the circumstances giving rise to your claim. Claims submitted more than one (1) year after the date of the circumstances giving rise to your claim will not be considered.

You should file your claim for benefits with the Claims Administrator at the following address:

Textron Aviation
Attn: Health Services Manager
One Cessna Blvd
Wichita, Kansas 67215

PlaneHealthy@txtav.com

Your claim must include sufficient information regarding the circumstances giving rise to your claim, including the names of any relevant individuals, dates, and any other information needed to evaluate your claim.

Time Frame for Initial Claim Determination

Unless otherwise provided, your claim for benefits will be processed under the procedures described below.

The Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. A 15-day extension may be allowed to make a determination, provided that the Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also describe the required information. You then have 45 days to provide the information needed to process your claim.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The reason(s) for the adverse benefit determination.
- References to the provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.

Effect of Failure to Submit Required Claim Information

If the Claims Administrator determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim, you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the Claims Administrator's request for information or upon a demonstration to the satisfaction of the Claims Administrator that under the circumstances the Claims Administrator's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Claims Administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Claims Administrator deems relevant.

Appealing a Denial

Filing an Appeal

If you receive an adverse benefit determination, you must ask for an appeal from the Plan Administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file your appeal. If you do not file your appeal (with the Plan Administrator) within this time

frame, you waive your right to file an appeal of the determination.

Please include with your request for appeal all comments, documents, records, and other information relating to the denied/withheld benefit. Your request for appeal should be sent to the following address:

Textron Aviation
Attn: Health Services Manager
One Cessna Blvd
Wichita, Kansas 67215

PlaneHealthy@txtav.com

The Plan Administrator will review your appeal and will communicate its appeal decision to you in writing within 60 days of receipt of your appeal.

Upon its receipt your appeal will be reviewed in accordance with the terms and provisions of this section and the guidelines of the Plan Administrator. Your case, including evidence you submit, if appropriate, will be reviewed by the Plan Administrator or its designee(s).

Rights on Appeal

When you file an appeal, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.

- A review in which the Plan Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions.
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment.
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- The reason(s) for the adverse benefit determination.
- References to the provisions on which the benefit determination is based.
- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- A description of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures.

Deadline to Bring Legal Action

You must use and exhaust the administrative claims and appeals rights set forth in this SPD before bringing a suit in federal court. Similarly, failure to follow the SPD's prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal rights, you may bring suit in a federal

district court only if you file your action or suit within two (2) years of the date after the adverse benefit determination is made on final appeal.

Administrative Information

Aviation provides the benefits described in this SPD.

Plan Sponsor

The Plan Sponsor is Textron Inc.

Plan Administrator

The Plan Administrator of the Plan is Textron Inc. Textron has delegated the responsibility to administer the Center component of the Plan (the "Center Component") to Aviation. Aviation has discretionary authority to interpret Center Component Plan provisions, construe unclear terms, determine who is eligible to use the Center and otherwise make all Center Component decisions and determinations. By using the Center, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator as follows:

Textron Aviation
Attn: Health Services Manager
One Cessna Blvd
Wichita, Kansas 67215

PlaneHealthy@txtav.com

The Plan Administrator or any plan fiduciary may engage attorneys, accountants, actuaries, consultants, and others to advise it on issues related to the Center. When it does so, the adviser's client is the Plan Administrator or plan fiduciary and not any participant or beneficiary using the Center. Communications between an attorney and a client are "privileged," which means that they may not be disclosed to third parties unless the client waives the privilege. The Plan Administrator intends and expects to preserve this attorney-client privilege, and all other rights to maintain confidentiality, to the full extent permitted by law. No participant or beneficiary will be permitted to review any communication between the Plan Administrator or plan fiduciary (including any representative or agent of the Plan Administrator or plan fiduciary) and any of its attorneys or other advisers with respect to whom a privilege applies, unless mandated by a court order.

Claims Administrator

The Claims Administrator is Aviation or its authorized designee. Subject to the overall authority of the Plan Administrator, the Claims Administrator or its authorized designee has discretionary authority to interpret Plan provisions and determine benefit claims.

Employer Identification Number

Textron Inc.'s employer identification number, assigned by the IRS, is 05-0315468.

Name of Plan, Type of Plan and Plan Number

Access to the Center for personal medical and pharmacy services is a component of the **Textron Non-Bargained Medical Plan and the Textron Bargained Medical Plan for certain employees** (the "Plan"), which are ERISA group health plans that provide health and welfare benefits. The Textron Non-Bargained Medical Plan identification number is 525, the Textron Bargained Medical Plan identification number is 526. All benefits paid for the Center are paid from Aviation's general assets. There is no special fund or trust or insurance from which benefits are paid.

Plan Year

The Plan Year is the year by which the Plan's fiscal records are kept. The Plan Year is the calendar year.

Type of Administration

The Center Component of the Plan is administered by Aviation.

Agent for Legal Process

If you wish to file suit, legal papers may be served on your Claims Administrator at the address listed elsewhere in this document or on the Plan Administrator at the address above.

Changes to the Center and Termination of Center

Aviation reserves to itself or its designee the right to change or terminate the Center or any of the Center benefits at any time to the extent permitted by law. This can occur without the consent of, and without prior notice to, any employee, eligible dependent or beneficiary covered by these benefits. Any amendments or termination will be communicated in writing.

Qualified Medical Child Support Orders

You may be required by an order issued by a court or administrative agency to provide access to the Center for your child, even if the child does not live with you. If the order is determined to be a "qualified medical child support order" ("QMCSO"), Aviation will be required to provide access to the child as stated in the order. To request more information about QMCSOs, and to receive a free copy of the procedure used by Aviation to determine whether an order is a QMCSO, please contact the Plan Administrator at the address listed elsewhere in this notice.

Collective Bargaining Agreements

The Plan is administered in consideration of the terms of multiple collective bargaining agreements. A copy of these agreements may be obtained upon written request to the Plan Administrator and is available for examination by participants and their beneficiaries. Notwithstanding anything contained herein to the contrary, Textron will comply with the requirements of a specific bargaining agreement or regulation, if applicable.

Your Rights Under ERISA

You are entitled to certain rights and protections under ERISA. ERISA provides that you shall be entitled to:

RECEIVE INFORMATION ABOUT PLAN BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of access to the Center as a result of a qualifying event. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part (and you have exhausted the administrative remedies available under the Plan), you may file suit in a state or Federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Center, you should contact the Plan Administrator. (For questions regarding eligibility to use the Center, please contact Aviation at 316-517-5252, Option 5). If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT A
Continuing Access to the Center Under COBRA

Continuing Access to the Center Under COBRA

Introduction

If your employment terminates for any reason, your access and your dependents' access to the Center is cancelled. This section of the SPD has important information about your right to COBRA continuation coverage, which is a temporary extension of your right to use the Center. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

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. Under COBRA, you and your dependents may be eligible to extend access to the Center for a certain period of time. COBRA can become available to other members of your family who have access to the Center when they would otherwise lose it.

What is COBRA continuation coverage?

COBRA continuation coverage is continuation of coverage; in this instance, it is continued access to the Center when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if you lose access to the Center because of the qualifying event.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose access to the Center because one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose access to the Center because of the following qualifying events:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or

both), or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose access to the Center because of the following qualifying events:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both),
- The parents become divorced or legally separated, or
- The child stops being eligible to access the Center as a "dependent child."

Note: *A child born to, adopted by, or placed for adoption with the parent-employee during the period of COBRA coverage would also be a qualified beneficiary.*

When is COBRA continuation coverage available?

COBRA continuation coverage will be offered to qualified beneficiaries within 30 days after Aviation processes the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify Aviation within 60 days after the qualifying event occurs by contacting them at the address in the ***Whom to Contact About Your COBRA Rights*** section.

How is COBRA continuation coverage provided?

Aviation will notify you, your spouse and/or dependent(s) of your (their) right(s) to elect continued access to the Center after your termination or other qualifying event is processed. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children. Once you receive notification from Aviation of your right to elect COBRA continuation coverage, you must notify them that you want to elect COBRA continuation coverage, within 60 days of the later of:

- The date your coverage ends, or
- The date that you are notified of your right to COBRA continuation coverage.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

Length of COBRA Coverage

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family using the Center is determined by Social Security to be disabled and you notify Aviation within the time limit described below, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

You must provide notice of disability to Aviation **within 60 days of the latest of:**

- The date of the Social Security Administration's disability determination,
- The date of the covered employee's termination of employment or reduction in hours, or
- The date on which the qualified beneficiary would lose access to the Center as a result of the termination of employment or reduction in hours, ***and***
- Prior to the end of the 18-month COBRA continuation period (following the covered employee's termination of employment or reduction in hours).

You must notify Aviation of the disability determination, either in writing or by telephone at the address in the ***Whom to Contact About Your COBRA Coverage Rights*** section.

Your notice must include the information outlined below:

- The name of the Center;
- The name and address of the employee or former employee who has or had access to the Center;
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction in hours);
- The date that the covered employee's termination of employment or reduction in hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost access to the Center due to the termination or reduction in hours and who are receiving COBRA coverage at the time of the notice;
- The name and address of the disabled;

- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contact information of the individual sending the notice. You may be asked to provide Aviation with a copy of the Social Security Administration's determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if Aviation is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must provide this notice **within 60 days of the later of**:

- The date of the second qualifying event (i.e., divorce or legal separation, the covered employee's death or entitlement to Medicare benefits, or a child's loss of dependent status); or
- The date on which the covered spouse or dependent child would lose access to the Center as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still able to use the Center).

You must notify Aviation of a second qualifying event (i.e., divorce or legal separation, the covered employee's death or entitlement to Medicare benefits, or a child's loss of dependent status), either in writing or by telephone at the address in the ***Whom to Contact About Your COBRA Coverage Rights*** section.

Your notice must include the information outlined below:

- The name of the Center;
- The name and address of the employee or former employee who has or had access to the Center;
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction in hours);
- The date that the covered employee's termination of employment or reduction in hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost access to

the Center due to the termination or reduction in hours and who are receiving COBRA continuation coverage at the time of the notice;

- The second qualifying event (a divorce or legal separation, the covered employee's death or eligibility for Medicare benefits, or a child's loss of dependent status);
- The date that the divorce or legal separation, the covered employee's death or eligibility for Medicare benefits, or a child's loss of dependent status happened; and
- The signature, name and contact information of the individual sending the notice.

You may also be asked to provide Aviation with the appropriate documentation to determine whether you gave timely notice of the second qualifying event—and, therefore, are entitled to an extension of COBRA coverage.

If your access to the Center is cancelled and later a divorce or legal separation occurs, and you are notifying Aviation that your access to the Center was cancelled in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation, in accordance with the notice procedures described above. You must also provide evidence satisfactory to Aviation that your access was cancelled in anticipation of the divorce or legal separation.

COBRA continuation coverage, i.e., continued access to the Center, if any, will begin on the date of the divorce or legal separation, not the date that your coverage is eliminated.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage for continued access to the Center, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered dependent first becomes entitled to Medicare.
- The date the entire Plan ends.
- The date that access to the Center would otherwise terminate as described in the SPD.

Cost of COBRA Continuation Coverage

COBRA continuation coverage for access to the Center is provided at no charge to you, because Aviation does not change for access to the Center. As discussed previously in this SPD, your COBRA continuation coverage consists **only** of continued access to the Center. If you use the Center, you will be charged the full cost of the services that you or your dependents receive.

Are there other coverage options besides COBRA Continuation Coverage?

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

Reporting Address Changes

To protect your rights and your family's rights, you should keep Aviation informed of any changes in your address and your dependents' address(es) by contacting Aviation at the address copied below under ***Whom to Contact About Your COBRA Coverage Rights***.

You should keep a copy for your records of any notices you send to Aviation.

Whom to Contact About Your COBRA Coverage Rights

If you have questions about your COBRA rights, please contact Aviation at the following address.

Textron Aviation
Attn: Health Services Manager
One Cessna Blvd
Wichita, Kansas 67215

PlaneHealthy@txtav.com

The contact information for the Center may change from time to time.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA) and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at 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, go to www.healthcare.gov.