PetSmart LLC
SmartChoices Benefit Plan
Summary Plan Description

Effective January 1, 2024

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Introduction

This summary plan description ("SPD") describes the health and welfare benefits available to eligible employees of PetSmart LLC (the "Company") and their eligible dependents effective as of January 1, 2024. The benefits are governed by the certificates of insurance issued by the insurers, administrative services agreements, this summary plan description, or other governing documents referenced herein. *See the "Administrative Information" section for plan document information.*

This SPD can help you better understand and use your health and welfare benefits, replaces previous SPDs, and is intended to comply with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It is to your advantage to read through this SPD, learn how the benefits work, and share this information with your family.

Incorporated Documents

This SPD incorporates by reference the summary documents for the following benefits, as furnished by each provider chosen by the Plan Sponsor:

- Medical / Prescription Drug (including Mental Health / Substance Use Disorder and Behavioral Health) Benefits
- Dental Benefits
- Vision Benefits
- Short-Term Disability Insurance
- Long-Term Disability Insurance
- Life Insurance
- Accidental Death and Dismemberment Insurance
- Employee Assistance Program
- Health Care Flexible Spending Account
- Health Savings Account (for purposes of Participant pre-tax contributions)
- Voluntary Accidental Injury Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

The documents furnished by the providers, issuers and administrators for these listed benefits and coverages are incorporated into this SPD and serve as the source of specific information relating to your health and welfare benefits. This SPD and the listed documents function as one document to summarize your benefits.

While this SPD and the incorporated documents describe your health and welfare benefits, if there is any inconsistency or discrepancy between the provisions of this document and the official plan documents, your rights and benefits will be determined under the official plan documents for the PetSmart SmartChoices Benefit Plan and the PetSmart Flexible Benefits Plan (together, the "Plan").

Plan Contacts

For additional information about your health and welfare benefits, you may contact the following:

Contact	Reasons to Access
Plan Administrator	
PetSmart LLC 19601 North 27th Avenue Phoenix, AZ 85027 Telephone: 1-866-263-8411 HRSharedServices@petsmart.com	▪ Verify your eligibility.
Benefits Administrator	
PetSmart Benefits Portal digital.alight.com/petsmart 1-888-481-0101	▪ Review your benefits enrollment. ▪ Get answers to most general questions. ▪ Get information about employee contributions and deductions
Claims Administrators	
Please see the Appendix: Plan Contacts at the end of this SPD for contact information for your specific enrolled benefits.	▪ Review your benefits. ▪ Locate a participating provider. ▪ Obtain a predetermination. ▪ Review your rights as a patient. ▪ Speak with a claims service representative. ▪ Request or download a claim form.

Your Health and Welfare Benefits

Health and Welfare Benefits Under the Plan

Full-time employees working thirty-two (32) or more hours per week (thirty (30) hours for medical benefits) are eligible for the following health and welfare benefits under the Plan:

- Medical / Prescription Drug (including Mental Health / Substance Use Disorder and Behavioral Health) Benefits
- Dental Benefits
- Vision Benefits
- Short-Term Disability Insurance
- Long-Term Disability Insurance
- Life Insurance
- Accidental Death and Dismemberment Insurance
- Employee Assistance Program
- Health Care Flexible Spending Account
- Health Savings Account ("HSA")
- Voluntary Accidental Injury Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

The details of each of these health and welfare benefits are described in the incorporated documents.

Cost of Coverage

The cost of coverage varies among the Plan's benefits. The Company pays the entire premium for Basic Employee Life Insurance and pays the entire premium for Short-Term Disability Insurance when required by applicable law. All full-time salaried employees, full-time hourly employees assigned to Phoenix Home Office, and full-time hourly store leaders are automatically provided Long-Term Disability coverage. If you are a full-time hourly store or Distribution Center employee, you can purchase Long-Term Disability coverage.

Payment of premiums for Medical / Prescription Drug benefits are shared between you and the Company.

You will pay the entire premium amount for Dental, Vision, Accidental Death and Dismemberment Insurance, the entire amount of your Health Care Flexible Spending Account contributions, your Bronze Plan (HDHP Core with HSA), and voluntary insurance benefits Hospital Indemnity, Critical Illness and Accidental Injury. Depending on the particular benefits selected, your employee contributions may be deducted from your paycheck on a pre-tax basis or paid with after-tax dollars. *See the Annual Enrollment materials and Summary of Benefits for more information about paying for your benefits.*

The Company determines the amount of your employee contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the Plan Administrator to receive information about your employee contributions.

Participating Provider Networks and Directories

In order to provide participants with the most current network information, the plan or insurer is required to maintain a database on a public website that lists current information for providers and facilities that participate in its network (either directly or indirectly). The database information will be verified and updated as necessary, no less than every ninety (90) days. You can access this information by phone or by going to

the websites listed in the "*Plan Contacts*" in the Appendix to this SPD. For telephone requests, you should receive a response within one business day through a written electronic or print communication.

If you are provided information via the online directory or as a response to a telephone request regarding a provider's in-network status that turns out to be incorrect, you will not be responsible for paying a cost-sharing amount higher than the in-network amount that would have applied if you had seen a participating provider. Further, any cost-sharing amounts paid by you will count towards your in-network deductible and out-of-pocket maximum.

Patient Protection Statement Regarding Provider Designation

For purposes of the Plan's medical coverage, you (or your covered family members) generally may be required or permitted to designate a primary care provider. If that is the case, you have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. If you do not make this designation, the Plan may designate one for you. For your covered child, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider and for a list of the participating primary care providers, contact the Claims Administrator for your coverage at the address provided in this SPD.

For purposes of the Plan's medical coverage, if the Plan requires the designation of a primary care provider, you (or your covered family member) do not need prior authorization from the Plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator for your coverage at the address provided in this SPD.

Qualified Medical Child Support Orders ("QMCSO")

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). A QMCSO cannot require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's coverage.

The Plan provides health benefits for your child pursuant to the terms of a QMCSO. This coverage may apply even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment season restrictions that might exist for dependent coverage.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The Company follows certain procedures to determine if a medical child support order is "qualified." You may request, free of charge, a copy of the Plan's QMCSO administrative procedures from the Plan Administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator.

If the Company receives a valid QMCSO, you may enroll a dependent child for health benefits under the Plan pursuant to the QMCSO's terms. The change you elect takes effect as of the date the Plan Administrator processes the QMCSO.

Standards for Mothers and Newborns

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

Your Rights Following a Mastectomy

The Plan includes health benefits for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, benefits will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Benefits will be subject to the same annual deductibles and coinsurance provisions that apply for all other medically necessary procedures under the Plan.

Consumer Protections under the Affordable Care Act

The Company's medical and prescription drug plan benefits provide you with certain protections—sometimes referred to as "group market reforms" or "consumer protections" under the Affordable Care Act, including:

- Prohibition of preexisting condition exclusions
  - The Plan does not impose any preexisting condition exclusions.
- Prohibiting discrimination against participants and beneficiaries based on a health factor
  - The Plan does not discriminate against participants and beneficiaries based on a health factor.
- Prohibition on waiting periods that exceed ninety (90) days
  - See the *Eligibility* section of this SPD for more details.
- Prohibition on lifetime or annual dollar limits on essential health benefits
  - The Plan does not impose any lifetime or annual dollar limit on essential health benefits.
- Prohibition on rescissions
  - The Plan will not retroactively rescind your coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. If coverage is cancelled or discontinued prospectively, that is not considered a rescission. It is also not a rescission if you do not pay your required premium and your coverage is cancelled or discontinued back to the date that the premium was not paid. The Plan will provide you with at least thirty (30) calendar days' advance notice before your coverage is rescinded. If your coverage is or will be rescinded, you have the right to file an appeal.
- Eligibility of Children until at least age twenty-six (26)
  - The Plan extends coverage to adult Children until the end of the month in which a Child attains age twenty-six (26).
- Summary of benefits and coverage and uniform glossary
  - Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. You may request a paper copy free of charge from the Plan Administrator.
- Solely with respect to insured medical benefit options, the Plan complies with the Affordable Care Act's medical loss ratio requirements.
- Accommodations in connection with coverage of preventive health services

- The Company's medical and prescription drug plan options provide preventive care benefits, when obtained in-network without cost-sharing. See the summary of your medical plan benefits for more details on what constitutes preventive care for this purpose; the list changes periodically. Preventive care generally includes items and services with a rating of "A" or "B" under the United States Preventive Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC; and with respect to children and women, certain preventive care and screenings based on guidelines supported by the Health Resources and Services Administration.
    - General information pertaining to other preventive services and a prescription drug list is available at https://www.healthcare.gov/preventive-care-benefits/. The list of in-network preventive care items and services with no cost sharing includes: certain screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations, counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as bowel preparation medications, anesthesia, and polyp testing) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.
    - For women, the medical and prescription drug options also will cover an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support, supplies and counseling (including lactation counseling services); and screening and counseling for interpersonal and domestic violence. In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your Physician prescribes this type of medication to reduce your risk of breast cancer, contact the Claims Administrator to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.

NOTE: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

- Internal claims and appeals and external review process
    - See the *Claims and Appeals Procedures* section of this SPD for more information.
- Consumer patient protections (prevention of surprise medical bills, choice of health care professional and coverage of emergency services)
    - If you need "emergency services," the medical options offered under the Plan will provide you with coverage regardless of whether the provider for such "emergency" services is in-network or out-of-network. Also, "emergency services" are subject to special cost-sharing rules that prohibit the Plan from imposing a higher cost-sharing amount (for example, copayment or coinsurance) for out-of-network emergency services than it does for in-network emergency services. For more information, including what constitutes an emergency service, contact the Claims Administrator.
    - The medical and prescription drug options offered to you will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.
- Limitations on your out-of-pocket expense maximum
    - As required by the Affordable Care Act, your total in-network out-of-pocket costs will not exceed the IRS maximum, as indexed annually. The Affordable Care Act's individual out-of-pocket expense

maximum applies to each covered individual, whether the individual has self-only, family, or another coverage tier. So, it's possible that this limit will result in payment for an individual before the family out-of-pocket expense maximum is hit for a high deductible health plan ("HDHP") if the HDHP has a family deductible that is less than the self-only limit under the Affordable Care Act.

  - The maximum imposed by the Affordable Care Act creates a separate, legally required limit on in-network out-of-pocket costs, which requires that additional costs count toward these limits even if they do not apply toward your medical option's out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copayments, coinsurance, and eligible prescription drug expenses. Out-of-pocket expenses that do not apply toward your in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician.
  - The actual out-of-pocket expense maximums under the medical and prescription drug option that you elect may be lower than the legal maximums. Please contact your medical Claims Administrator for more information. See the "*Plan Contacts*" section for contact information.

- Coverage for individuals participating in approved clinical trials
  - You are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your medical Claims Administrator for more information. See the "*Plan Contacts*" section for contact information.

Continuity of Care Provisions

In certain circumstances, the Plan will provide continuing coverage for courses of treatment if your network provider moves out-of-network due to a contract termination between the Plan (or insurer) during the course of the plan year. In these situations, you may be able to temporarily maintain access to your provider or facility under the same terms and conditions as they were available in-network.

In order to qualify for continuity of care coverage (also called transitional care), you must already be:

- undergoing a course of treatment for a serious and complex condition,
- in institutional or inpatient care,
- scheduled for non-elective surgery (including receipt of post-operative care with respect to such surgery),
- pregnant, or
- terminally ill.

For purposes of this provision, a serious and complex condition can be either an acute or chronic illness. In the case of an acute illness, it is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness, it is a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

If a provider's network status changes during the plan year, the insurer will notify you of the network status change in a timely manner and inform you of the right to request transitional care. If you qualify for continuity of care coverage, you may be able to access services for up to ninety (90) days after this notice is provided or until you are no longer a continuing care patient (whichever comes first).

Providers will not balance bill you for services provided under the continuity of care provisions; they must accept in-network payments from the insurer and cost-sharing amounts from you as payment in full.

Coordination of Benefits

The incorporated documents detail the way health and welfare benefits are paid if you or any one of your dependents is covered under more than one benefit plan.

Expenses for Which a Third Party May Be Responsible

Reimbursement and Subrogation. The Plan is not required by law to cover health expenses that you or dependents may be able to recover from a third party.

If the Plan Pays Benefits When a Recovery May Be Available. By participating in the Plan, you and your dependents agree to the following provisions with respect to any expenses that the Plan advances and for which a Recovery may be available. The Plan would not have covered any of those expenses, but for this agreement to reimburse the Plan in full in accordance with this section.

Definitions

- "Insurance Coverage" means any non-Plan coverage providing medical expense coverage or liability coverage. It includes such things as uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any other insurance coverage.
- "Responsible Party" means any party (other than the Plan) actually or potentially responsible for making any payment to you or your dependent due to your or your dependent's injury, illness or condition, including the party's insurer.
- "Recovery" means any amount you or your dependent receives from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, including amounts designated as pain and suffering damages, non-economic damages, non-medical damages, or general damages, and even if the Responsible Person is not liable or denies liability. A Recovery includes amounts family members receive because of or related to your or your dependent's injury, illness, or condition.

Right of the Plan to Be Reimbursed. The amount the Plan advanced to pay for treatment of your or your dependent's injury, illness, or condition must be fully repaid (to the extent your or your dependent's net Recoveries (i.e., after reduction for reasonable attorney's fees and recovery costs) for or relating to that injury, illness, or condition) before you and/or your dependent or anyone else may keep any portion of the Recoveries.

Promise to Pay Plan Amount it is Due. You and your dependents promise to pay the Plan the amount it is due under this section. This promise shall be an enforceable contract governed by Arizona law. You or each of your dependents agree to pay to the Plan any amount you or they receive because of your or your dependent's injury, illness or condition, to the extent necessary to fully reimburse the Plan.

Participant Will Hold Recovery in Trust for the Plan. You and your dependents shall hold any Recovery in trust for the Plan's benefit to the extent of the Plan's repayment right. Each person holding any Recovery in trust for the Plan shall be a Plan fiduciary for that limited purpose, and shall be personally liable to the Plan for any loss the Plan suffers as a result to his or her fiduciary breach. However, such a person shall not have any other fiduciary powers or rights. For example, such a person will not be eligible for the indemnification or insurance protection provided to other Plan fiduciaries, notwithstanding anything else to the contrary.

Plan's Lien on Recoveries. The Plan will automatically have a first priority lien on any Recovery to the extent of benefits advanced by the Plan for the treatment of the illness, injury, or condition to which the recovery relates. The lien shall arise on any Recovery whether by settlement, judgment, insurance, net of reasonable attorney's fees and recovery costs. The lien may be enforced against any party who possesses the Recovery.

Assignment of Recovery to Plan. In order to secure the rights of the Plan under this section, you and your dependents hereby assign to the Plan any amounts they may recover that relate to expenses the Plan advanced under this section, to the extent of such advances.

Unavailability of Equitable or Other Defenses. No equitable defenses, including such things as make-whole, common fund, and unjust enrichment principles, shall reduce the Plan's rights under this section. For example, if you or your dependent recovers less than all the damages sought, the Plan's repayment rights shall not be reduced. You and/or your dependents promise not to assert, and hereby, waive any equitable defenses to or limitations on the Plan's right to recover the amount due under this section.

Obligation to Cooperate. You and/or your dependents shall fully cooperate with the Plan's efforts to recover the amount it is due, including permitting the Plan or its agents to conduct investigations reasonably needed to enforce the Plan's rights under this section. You and/or your dependents must notify the Plan Administrator that you are considering seeking a Recovery or similar amounts no later than thirty (30) days after you begin considering pursuing such a claim. You and/or your covered dependents shall provide all information requested by the Plan, any Claims Administrator, or their representatives including, submitting forms or statements as the Plan may reasonably request. You and/or your covered dependents shall do nothing to prejudice the Plan's rights under this section.

Plan's Right to Recover Collection Expenses. If the Plan incurs costs, such as attorney's fees, to recover amounts it is due under this section, those costs shall be added to the amount the Plan is entitled to recover under this section.

Suit to Enforce Plan Recovery. The participant and his or her covered family members agree that the Plan may bring suit to recover amounts due under this section in Federal or state court in Arizona or in any other court of competent jurisdiction, and they agree to submit to each such jurisdiction, waiving whatever rights they might have by reason of their present or future domicile.

Right of Plan to Pursue Recovery Independently. The Plan shall be subrogated to (stand in the place of) you and/or your covered dependents, and you and/or your covered dependents hereby assign, all rights of recovery you have against anyone due to injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert this right independently of you and/or your covered dependents. Nothing in this subsection shall preclude you or your dependents from pursuing such a claim while the Plan is not independently pursuing it.

Attorneys & Agents. You and your covered dependent's attorneys and agents shall be bound by all the provisions of this section, to the same extent as you and your covered dependents. You and your covered dependents attorneys' and agents' violations of this section shall be treated as a violation by you and your covered dependents of your or your dependent's obligations.

Consequences of Violating Obligations. If you and/or your covered dependents, or your attorneys or agents, fail to repay the Plan, cooperate with the Plan in its efforts to recover such amounts, or do anything to hinder or prevent such a recovery, in addition to any other remedies available to the Plan, you and/or your dependents shall forever cease to be entitled to any further Plan benefits, except to the extent prohibited by the Affordable Care Act or ERISA. In addition, the participant and his or her covered family members, by accepting Plan benefits, authorize the Company and the Plan to use the self-help remedy of withholding any amounts due under this section from any other amounts they are owed by the Company, Plan, or any other Company-sponsored arrangement, subject to any applicable state laws, including laws governing wage deductions.

Recovery of Overpayments. If Plan benefits are paid by mistake to any person or entity, the recipient must repay the mistaken payment to the Plan immediately. By accepting Plan coverage, you and/or your covered dependents are deemed to agree that if you or they do not repay the mistaken payment to the Plan promptly after it requests repayment, then you and/or your covered dependents will pay all attorneys' fees the Plan incurs in successful attempts to recover such amounts. In addition to any other recovery rights it may have, the Plan shall have the right to recoup the overpayment from any future benefits payable to you and/or your covered dependents. To enforce its repayment rights, the Plan shall have a first priority, equitable lien on all Plan benefits paid to you and/or your covered dependents. The Plan's rights under this Section are in addition to any other remedies it may have in law or equity, and the Plan Administrator's enforcement of the Plan's rights under this Section shall not curtail the Plan's right to enforce any other remedies it may have.

Alienation of Interests. To the maximum extent permitted by law, you and/or your covered dependents' rights under the Plan may not be voluntarily or involuntarily assigned or alienated. As a matter of convenience, the Plan may provide health benefits on behalf of participants and beneficiaries by paying their respective health care providers directly rather than requiring such individuals to first pay the provider and then request reimbursement from the Plan. However, such providers shall not be considered Plan participants or beneficiaries for any Plan purpose.

Your Prescription Drug Benefits

When you enroll in the Medical Plan, you are automatically enrolled in the Prescription Drug Program.

NOTE: **The information below applies to you if you are enrolled in a self-funded medical option, which include the plans with Aetna, Anthem, Cigna and UnitedHealthcare. If you are enrolled in any other medical plan option, refer to the plan summary provided by the insurance carrier for information on your prescription drug benefits.**

When you use a participating CVS Caremark network Pharmacy, your copay or coinsurance amount will depend on the type of prescription. You will generally pay the lowest amount for any generic drug, a mid-level copay or coinsurance for cost-effective, preferred brand-name drugs, a higher copay or coinsurance amount for non-preferred brand- name drugs and the highest copay or coinsurance amount for specialty drugs. Specialty drugs are only available through the CVS Caremark Specialty Pharmacy. To receive your benefit, go to a drug store that accepts your CVS Caremark prescription drug card. To find a participating drug store near you contact CVS Caremark at 1-855-821-0355 or visit their website at www.caremark.com. Prescriptions purchased at out-of-network pharmacies are not covered.

How Does the Prescription Benefits work with the HDHP? The High Deductible Health Plan (HDHP) requires you to pay the full negotiated cost for your care until you reach your deductible for most health care expenses, including most prescription medications. After you meet the deductible, you pay only the coinsurance, and your plan pays the rest. Petsmart understands that some medications can help prevent disease or help manage existing conditions to try and avoid future complications. For this reason, Petsmart offers a preventive drug list, which reduces your cost for select prescriptions that help prevent chronic health conditions, when taken regularly. If you take medications on the preventive drug list, you will pay only the coinsurance for these medications even if you have not yet met your annual plan deductible. The list of covered preventive drugs can be found at benefits.petsmart.com or at www.caremark.com.

Examples of preventive medications:

- The treatment of high cholesterol with medications such as statins to prevent heart disease.
- Using medication such as an ACE inhibitor to prevent heart attack or stroke in members who have already suffered a heart attack or stroke.

Information on specialty medications on the HDHP plan are reviewed in the section PrudentRx Co-Pay Program for Specialty Medications

What is the CVS Caremark Performance Drug List (PDL)? The Prescription Drug Program has adopted the CVS Caremark's current Advance Control Formulary as its guide within select therapeutic categories for plan members and health care providers. Drugs determined as "non-formulary" based on CVS Caremark's current formulary are not covered by the Plan. Certain products or categories, regardless of their appearance in this document may not be covered by the plan. The Caremark Performance Drug List, aka "Commonly Prescribed Medications List" is included with your card(s) or a copy can also be obtained online at www.caremark.com.

What are Generic Drugs? Generic drugs are approved to be as safe and effective as their brand name counterparts, and on average cost 50% less than brand name drugs. Generic drugs contain the same active ingredients and are available in the same strength and dosage form as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) regulates the manufacture of all generic drugs, which helps ensure their strength, quality and purity. The FDA also requires generic drugs to be absorbed into the body at the same rate and to the same extent as the branded product, which ensures that generic and branded products provide the same effectiveness in children, adults, and the elderly.

What are Preferred Brand-Name Drugs? Preferred brand-name drugs are a selected list of medicines on the CVS Caremark Performance Drug List that are clinically appropriate and cost- effective to meet individual needs. You can view and download the CVS Caremark Performance Drug List by logging onto Caremark.com. (To register, go to http://www.caremark.com/register and have your participant ID handy.) You may want to print a copy of the drug list and take it to your Physician the next time you need a

prescription. If a generic isn't available for your prescription, ask your Physician to prescribe a preferred brand-name drug from the list, if appropriate for your needs.

What are Non-Preferred Brand-Name Drugs? These are brand-name drugs that aren't part of the CVS Caremark Performance Drug List and will require you to pay a higher co-payment than a preferred or generic drug.

How do I see if a drug is covered or check the cost once I am enrolled in the plan?

If you are already enrolled in a CVS plan, you can register online at Caremark.com to check your drug cost and coverage. After logging in, select red Check Drug Cost and Coverage icon on the upper right-hand side of the landing page. Or, under the header, hover over the "Plan & Benefits" tab and select "Check Cost Drug & Coverage".

You will be prompted to enter in the drug name and strength and the pharmacy you would like to fill at, then select the drug name and strength and hit "Search". You will be brought to the results, which will show you the cost of a thirty (30)-day supply and a ninety (90)-day supply (if applicable). If your drug is not covered, or requires a prior authorization, or is a specialty medication that must be filled at CVS Specialty®, it will be indicated here.

If you do not already have an account with Caremark.com or have not yet enrolled in the plan, you can find out the cost of medications and plan details by calling your Customer Care number is 855-821-0355 or by visiting the CVS pre-enrollment website at https://info.caremark.com/oe/petsmart.

How does the Out-of-Pocket Maximum work? Once you have reached the prescription Out-of- Pocket Maximum, the Plan pays 100% of eligible prescription drug expenses for claims incurred during the remainder of the calendar year. Items that are not included toward your Out-of-Pocket Maximums are excluded drugs, out of network claims, and the amount you pay over the generic drug cost when you request a brand-name drug when the Physician approves an available generic drug. See the Generic Substitution section listed below for more details.

Note that the copay and coinsurance amounts do not apply to covered FDA-approved contraceptives for women that are obtained with a prescription from a participating CVS Caremark network Pharmacy, including Caremark's mail order program. However, if the prescribed contraceptive has a generic equivalent, the copay or coinsurance will apply if you obtain the brand name version of the contraceptive.

How much do I have to pay for Prescriptions? Copay, coinsurance and out-of-pocket maximums amounts for retail and mail order pharmacies are shown on the chart below.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive Drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
30-Day Retail Supply					
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $12	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $80	You pay $70	You pay $60	You pay $50

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
90-Day Mail Order Supply					
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $30	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $125	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $200	You pay $175	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to the PetSmart Benefits Portal at **digital.alight.com/petsmart**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

*NOTE: For additional comparison, you may find Summaries of Benefits and Coverage on the PetSmart Benefits Portal at **digital.alight.com/petsmart**.*

How does Generic substitution work? You can save the most money by choosing generic drugs when available. Ask your Physician to authorize generic substitution when medically appropriate. CVS Caremark will never give you a generic instead of a brand-name drug without your Physician's permission.

If a generic drug is not available, you'll pay the brand-name copay or coinsurance. However, when a drug is available in generic form, but your Physician prescribes the brand-name drug, you'll pay the generic copayment or coinsurance plus the difference in cost between the generic and brand-name drugs.

If you or your Covered Dependent requests a brand-name drug when the Physician approves an available generic drug, you must pay the generic copay plus the difference in cost between the prescribed brand-name drug and its generic equivalent.

Important Information for Medicare Part D Eligible Individuals: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new voluntary prescription drug benefit (Part D) to the Medicare program for certain individuals. Group health plans that provide prescription drug coverage to individuals who are eligible for coverage under Part D must provide a notice to such individuals whether coverage under the group health plan is "creditable." Such individuals will need this information to decide whether keeping the group health coverage will allow them to delay enrolling in Medicare Part D and still avoid the Part D late enrollment penalty when they finally enroll in Part D. Medicare Part D Eligible Individuals will receive a separate creditable coverage notice at the appropriate time. See Notice at the end of this SPD.

Affordable Care Act Preventive Drugs

Some medications are covered by the ACA preventative drug list, and with a prescription will be covered with a $0 copayment or coinsurance. This list may be amended or changed based on rules of the ACA. Visit https://benefits.petsmart.com/us/forms-and-resources/ for the most up to date list.

Mail Order Prescription Drug Program

Through the Caremark.com mail order program, you save time and money by ordering up to a ninety (90)-day supply of prescription medications taken for ongoing treatment of conditions, such as diabetes, ulcers, arthritis, and heart problems. Some medications may be limited to a thirty (30)-day supply. Copay or coinsurance amounts for mail order prescription drugs are shown in the previous chart. Over-the-counter (i.e., nonprescription) drugs cannot be ordered through the Caremark.com mail order prescription drug program.

How do I place a Mail Order? Have your doctor write a ninety (90)-day supply prescription and indicate the number of refills for your maintenance medication.

- With your first order, use the preaddressed mail order form to mail your prescription, completed order form and your check or money order for your copay or coinsurance amount. You may also pay with your VISA, MasterCard, Discover or American Express card. Do not send cash.
- Caremark.com will mail your medication(s) and reorder instructions to your home address. All orders will be sent FedEx, UPS, or First-Class Mail. You may request next-day or second-day delivery for an additional charge. Allow fourteen (14) days from the day you mail your order until delivery. If you need a covered medication right away, ask your doctor to write two prescriptions – one to be filled by your local pharmacist for a thirty (30)-day supply and one to send to Caremark.com for up to a ninety (90)-day supply with the number of refills indicated.
- Or use the ninety (90)-day supply Maintenance Choice Program at CVS/pharmacy option listed below (availability is subject to state law).

What is the Maintenance Choice Program? For any maintenance medications you may receive two (2) thirty (30)-day supply fills at retail. On your third fill you need to receive a ninety (90)-day supply either at a CVS/pharmacy or Target/pharmacy or by using Mail Order. Regardless of which option you choose, you will pay the mail copay or coinsurance amount. Members have the ability to fill ninety (90)-day supplies through mail order or at a CVS/pharmacy or Target/pharmacy. This provides options to save when filling prescriptions for maintenance medications. To fill your medications by mail, follow the instructions above. To fill your prescriptions at retail, simply take your prescription written for a ninety (90)-day supply to any CVS/pharmacy or Target/pharmacy and receive the medication at same mail order copay or coinsurance amount. This program may be limited based on state rules that restrict this type of plan.

How do I get Refills? Refills for are permitted only when 75% of the prescribed mediation has been used. There are two easy ways to refill your prescriptions:

- call CVS Caremark at 1-855-821-0355 (as shown on your prescription label); or
- log on to www.caremark.com to order a refill.

You can also mail your refill requests by using the mail order form, but telephone and online orders are processed and delivered faster.

Prescription Management Programs

What is the CVS Caremark Specialty Guideline Management Program?

All specialty agents/medications are subject to Specialty Guideline Management (SGM) review. Specialty Guideline Management is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines. In addition, in order to address the changing marketplace dynamics and maximize appropriate use of generics, the SGM program incorporates specialty generic step therapy that requires the use of a cost-effective generic specialty medication as a first line therapy before targeted brands are covered. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved. Physician may call 1- 866-814-5506 to request an SGM review.

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the PrudentRx Solution has been made available for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the

PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible.

However, if you are not enrolled in the Bronze Plan, and you are participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution.

If you are enrolled in the Bronze Plan, and you are participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution, unless you are contributing to a health savings account (HSA). If you have elected to contribute to an HSA:

(i) for drugs listed on the plan's HDHP Preventive Drug List, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution; and

(ii) for all other drugs, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution only after your deductible has been satisfied.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications—in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

True Accumulation

Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Are there any Managed Drug limitations? CVS Caremark develops limitations to ensure safe and appropriate medication use. The list below includes those drugs subject to Managed Drug Limitations

(MDLs). Regardless of what is prescribed by your Physician, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark Customer Care at 1-855-821-0355.

- Migraine medications, including Amerge, Axert, Frova, Imitrex, Maxalt, Migranal, Relpax, Sumavel, Treximet and Zomig.
- Pain/Opiod medications, including Stadol NS and Toradol.
- Sedative/Hypnotics, including Ambien/CR, Dalmane, Doral, Halcion, Lunesta, ProSom, Restoril, Rozerem and Sonata.
- Proton Pump Inhibitors, including Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix and Zegerid.
- Lidocaine products
- Compound Products, A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Is Prior Authorization required? Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered.

In addition to the MDLs above, certain drugs or drug classes will require prior authorization for you to receive coverage for them. If you're taking one of these drugs, ask your doctor to call the CVS Caremark Prior Authorization Department at 1-888-413-2723. The request will be evaluated to determine if you qualify for Plan coverage of the prescribed therapy.

If you don't meet the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug.

Are there any Step Therapies? Yes, the plan's step therapy design requires the use of cost-effective alternatives, within the same therapeutic class, as first line therapy before targeted brands are covered.

Are there any Generic Step Therapies? Generic step therapy requires that a cost-effective generic alternative is tried first before targeted single-source brands are covered.

When a prescription for a targeted single-source brand is presented, the adjudication system will check for previous generic use. If the history shows generic use, the single source brand claim will pay. For targeted brands with no history of a generic trial, the retail pharmacist receives an electronic message with the generic-first criteria and a toll-free number for the physician to call for more information.

In the event the prescriber determines that a generic alternative is not right for the member, (s)he can call the Prior Authorization Department. Prescribers who call will be assisted by a team of professionals who educate the provider on lower cost covered medications to facilitate a seamless prescription conversion.

Are there any Exclusions? The following drugs and devices are not covered under the Prescription Drug Program:

- Anabolic Steroids.
- Antiobesity Agents.
- Anti-wrinkle Agents.
- Calcium Supplements.
- For Erectile Dysfunction.
- Fluoride Supplements (except Preventive Service Coverage listed below).
- Glucagon-Like Peptide-1 Agonists for weight loss.
- Hair Growth Stimulants.
- Hair Remover Agents.
- Infertility Agents unless enrolled in a fertility program.
- Contraceptives not approved by the Food and Drug Administration (FDA) for women.
- Contraceptives obtained without a prescription.

- Contraceptives for men.
- Abortifacient Drugs.
- Mineral and Nutrient Supplements.
- Pediatric Multivitamins w/Fluoride (tabs and drops).
- Select bulk powders and bases used in compound medications.
- Select Specialty Drugs in the following categories; for Multiple Sclerosis, Rheumatoid Arthritis, Hepatitis C, Psoriasis, Growth Hormone, Pulmonary Arterial Hypertension, and Osteoarthritis. Please note there are covered products in each of these classes and this list is updated quarterly.
- Over-the-counter (OTC) products or OTC equivalents and state restricted drugs.

Your Health Flexible Spending Account

Eligibility

Full-time salaried and full-time hourly employees employed by the Company for at least ninety (90) days are eligible to participate in the Company's Health Care Flexible Spending Account Plan ("Health FSA") and the Limited-Purpose Flexible Spending Account ("Limited Purpose FSA"). Coverage will begin on your ninety-first (91st) day of employment if you enroll during the thirty (30)-day initial enrollment period.

If you're a part-time employee and change to a full-time salaried or full-time hourly position, and you enroll when offered, your coverage under the Health and/or Limited Purpose FSAs will begin on the later of:

- your ninety-first (91st) day of employment (including both part-time and full-time service); or
- the first day of the month following the date you changed from part-time to full time.

Electing the Health Flexible Spending Account (FSA)

If you are eligible to participate in the health care flexible spending account benefit option of the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $3,200 per Plan Year (as may be adjusted for cost-of-living increases), credited to your Health FSA or Limited Purpose Health FSA. You can receive amounts from this account, in cash, as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA. You may request Claim Forms from the Claims Administrator to file your claim and receive reimbursement for eligible medical expenses.

General Purpose Health FSA: Generally, eligible medical expenses are expenses that you, your spouse or your dependent (determined as described in the next paragraph) have incurred that are not covered under any plan or otherwise reimbursed, that meet the Internal Revenue Code's definition of medical expenses, and that have not been taken as a deduction in any tax year. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise-eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

Limited Purpose Health FSA: The Limited Purpose FSA benefits provided under the Plan are for individuals participating in a medical plan that is a High Deductible Health Plan with a Health Savings Account ("HSA"). The Limited Purpose FSA is for the reimbursement of eligible out-of-pocket dental and vision expenses as well as certain preventive care expenses. Generally, eligible out-of-pocket dental, vision and preventive care expenses are expenses that you, your spouse or your dependent have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of out-of-pocket dental, vision and/or preventive care expenses (including legally obtained prescription drugs associated with dental, vision and/or preventive care services), and that have not been taken as a deduction in any tax year.

NOTE: You may also use your Health FSA to reimburse expenses for over-the-counter (OTC) drugs without a prescription; menstrual products; and personal protective equipment (such as masks, hand sanitizer and sanitizing wipes) for the prevention of Covid-19 (PPE); each as defined by the IRS. Please contact the FSA administrator for additional instructions regarding reimbursement of such amounts.

Health FSA Reimbursements

For purposes of Health FSA reimbursements, your "dependent" includes anyone who is your dependent for federal income tax purposes, as well as your biological, adopted or step-child or your eligible foster child if the child will be younger than twenty-seven (27) on the last day of the calendar year, even if the child is not a dependent for federal income tax purposes.

To be reimbursed from your Health FSA, you must submit to the Claims Administrator a request for reimbursement on a form provided by the Claims Administrator. (See "*Appendix: Plan Contacts*" for contact information.) You also must provide evidence of the amount, nature and payment of the underlying medical

expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests by no later than March 31 of the year following the last day of the Plan Year in which the expenses were incurred if you were an active employee on the last day of the Plan Year. If your employment terminates during the Plan Year, you must submit your requests within ninety (90) days following your employment termination date, unless you elect to continue Health FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). *See the "COBRA Continuation Rights" section for more details.*

If you have unused amounts in your Health FSA as of the end of the Claims Period for the Plan Year (March 31), then such excess amounts up to the limit communicated by the Claims Administrator (as adjusted from year to year) may be carried over and used to reimburse you for medical expenses incurred in the current and subsequent Plan Years. If, as of the end of the Claims Period for the Plan Year, you incurred expenses less than the maximum reimbursable amount, the remainder of the unused Health Care Spending Account in excess of the carryover limit shall be forfeited. If your employment terminates during the Plan Year, you must submit your request for reimbursement of expenses incurred while you were an active employee, within thirty (30) days following your employment termination date, unless you elect to continue Health FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). *See the "COBRA Continuation Rights" section for more details.*

Please note that amounts in excess of the carryover limit held in your Health FSA, for which a valid request for reimbursement has not been received by the deadline described above, will be forfeited.

Your Health Savings Account (HSA)

Eligibility

You may be eligible to contribute to an HSA if you are a participant in the Bronze Plan and you qualify as an HSA-eligible individual under federal tax law. If eligible, you may elect to make pre-tax payroll contributions to an HSA established in your name with an HSA custodian selected by the Company. Any limits on the amount you may contribute to your HSA will be determined by the Plan Administrator and announced to participants in advance of the dates they become effective. You may increase, decrease or revoke your HSA contribution elections once a month during the Plan Year. Your election changes only affect your future contributions and will become effective no later than the first day of the next calendar month following the date your election change was made. HSA contributions also are subject to annual limits that apply under the Internal Revenue Code. If you are an HSA-eligible individual, the maximum annual amount that you may elect to contribute to your HSA shall be the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution has been made. You may also make an additional catch-up contribution if you are age 55 or older, subject to statutory maximums.

You may use your HSA funds to pay for medical expenses, within the meaning of the Internal Revenue Code, which includes legally obtained prescription drugs, over-the-counter (OTC) drugs without a prescription, menstrual products and personal protective equipment such as masks, hand sanitizer and sanitizing wipes, for the prevention of the Covid-19 (PPE)). The Company may limit the amount you may contribute to your HSA through payroll deduction if it appears that contributions to the HSA exceed any limit that applies to you, but it is your responsibility to ensure your contributions do not exceed the statutory maximum amount.

To be eligible to make HSA contributions, in addition to being enrolled in the Bronze Plan, you may not be enrolled in certain other types of medical coverage that do not qualify as high deductible health plan coverage. For example, if you are covered under a spouse's health plan that is not a high deductible health plan, including a spouse's general purpose health flexible spending account, or if you are covered under any part of Medicare or TRICARE, you are not an eligible individual and so you may not receive or make HSA contributions. Also, if you are covered under the Plan's general purpose Health Care Flexible Spending Account, you are not eligible to make or receive HSA contributions. Whether you are an HSA-eligible individual is determined on a monthly basis. If you have any questions about whether any other coverage you have disqualifies you from being an HSA-eligible individual, please contact the Plan Administrator.

Your HSA belongs to you and is not a Company-sponsored plan. If you leave employment with the Company, the funds in your HSA are yours to keep. The HSA is not a part of this Plan and is not subject to the federal law known as ERISA or to the claims procedures described in this SPD. The "*Your Rights under ERISA*" section of this SPD does not apply to these benefits. For details about your HSA, you should contact the financial institution that maintains your HSA or contact the Plan Administrator if you need help in getting those details.

Eligibility

You and your eligible dependents are eligible for the health and welfare benefits under the Plan as summarized in this section.

Your Eligibility

Full-Time Associates

Full-time employees are eligible for the Plan as follows:

Generally, you are "full-time" if you work thirty-two (32) or more hours per week (thirty (30) hours for Medical Plan benefits) and are otherwise classified as a "full-time" employee by the Company.

Full-Time Salaried Employees: If you're a full-time salaried employee, you're eligible to participate in the Plan on the first day of the month following your date of hire except as noted in the "*Your Health Flexible Spending Account*" section to this SPD.

Full-Time Hourly Employees: If you're a full-time hourly employee, you must be employed by the Company for ninety (90) days to be eligible to participate in the Plan, and your coverage begins on your ninety-first (91st) day, assuming you enroll in the first thirty (30) days of employment during your initial enrollment period.

If you're a part-time employee and change to a full-time salaried position, any coverage under the Plan will begin on the first day of the month following the date you changed from part-time to full-time. If you're a part-time employee and changed to a full-time hourly position, your coverage will begin on the later of:

- Your ninety-first (91st) day of employment (including both part-time and full-time service); or
- The first day of the month following the date you changed from part-time to full time.

How Full-Time Status is Determined

For Medical Plan benefits, PetSmart will use a lookback measurement method to determine whether you are working at least thirty (30) hours of service per week. An hour of service is an hour for which you are paid or entitled to be paid by PetSmart for performance of duties for PetSmart, and each hour for which you are paid, or entitled to be paid by PetSmart for a period of time during which you perform no duties (for example, due to approved vacation, sick leave, holidays, or other approved leave of absence). The lookback measurement method is based on final Treasury Regulations under Internal Revenue Code Section 4980H.

The lookback measurement method applies to all PetSmart employees. If you are a new employee expected to work at least thirty (30) hours per week, you will be eligible to enroll in the Plan as explained above. If you are a new variable-hour employee, PetSmart will measure your hours-worked during an initial "measurement period" (described below) to determine whether you are eligible for medical plan coverage.

The lookback measurement method involves three different periods:

- A measurement period for counting an employee's hours of service. If you are an ongoing employee (one who has been employed for at least on full measurement period), this measurement period (which is also called the "standard measurement period") runs for twelve (12) months, generally starting and ending in October, determines your Plan eligibility for the following Plan Year (January 1 through December 31). If you are a new employee who is a variable hour employee (uncertain whether you will work at least thirty (30) hours per week), seasonal employee (employment associated with a season and lasting no more than 6 months) or part-time employee (expected to work less than thirty (30) hours per week) your "initial measurement period" will follow your employment start date with PetSmart and will last for twelve (12) months.

- A stability period is a period that follows a measurement period and administrative period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or not a full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain employed. The stability period will last for twelve (12) months. The stability period for ongoing employees will coincide with the plan year.
- An administrative period is a short period (no more than ninety (90) days) between the measurement period and the stability period when PetSmart performs administrative tasks, such as determining eligibility for coverage and conducting enrollment activities.

Note that special rules apply if you are rehired or return from an unpaid leave of absence. The rules for the lookback measurement method are very complex. This is just a general overview of how the rules work. Additional rules may apply to your situation. PetSmart intends to follow the final Treasury Regulations and any future guidance issued by the Internal Revenue Service when administering the look back measurement method. If you have any questions about this measurement method and how it applies to you, please contact PetSmart.

Ineligible Employees

The following categories of individuals are not eligible for the health and welfare benefits under the Plan:

- Nonresident aliens with no US source of income.
- Members of a collective bargaining unit covered under a collective bargaining agreement that does not provide for participation in this Plan.
- Fee-for-service employees.
- Leased employees.
- Independent contractors.

If you are excluded from the Company's definition of an eligible employee, you will not be eligible for benefits under the Plan even if a court, the Internal Revenue Service ("IRS"), or any other enforcement authority finds that you should be considered an eligible employee.

If You Become Ineligible

If you remain an employee of the Company but become ineligible because you no longer meet the eligibility requirements (for example, you no longer qualify as an eligible employee working at least thirty-two (32) hours per week or thirty (30) hours per week for medical benefits), you immediately become eligible once you meet the eligibility requirements again.

Eligible Dependents

Dependent Eligibility

For purposes of all benefits available under the Plan to dependents, your Spouse or your Domestic Partner (defined below) are considered an eligible dependent.

Your Child (defined below) is eligible for coverage offered to dependents under the Plan based on the following rules:

- Coverage for Children under Age 26. Any child of the participant who is under age twenty-six (26) is an eligible dependent under the Plan.
- Coverage for Children with Disabilities. Any eligible child of a participant who is incapable of self-sustaining support by reason of physical or mental disability is an eligible dependent under the Plan so long as all the following qualifications are met:
    - The child must have become disabled before reaching age twenty-six (26);

- The child must be enrolled in the applicable Plan coverage prior to the age limit applying, or within 31 days of the child's initial Plan eligibility, if later, for medical, dental, and vision benefits; and
- The child must remain continuously enrolled in the applicable Plan coverage thereafter.

Eligibility for this continued coverage is subject to periodic certification and approval by the Plan Administrator or a Claims Administrator. If you change medical options following a qualified status change or during an annual enrollment period, you may need to recertify the previously eligible child with the new medical option to continue coverage.

PetSmart requires proof of dependent eligibility for all dependents when added to the Medical / Prescription Drug Plans.

The following definitions apply for purposes of this Dependent Eligibility section:

- An eligible "child" of a Participant means:
  - Biological children;
  - Stepchildren (as determined under applicable state law) who reside with you the majority of the time, and only for so long as the marriage lasts);
  - Children of your Domestic Partner (who reside with you the majority of the time, and only for so long as the domestic partnership lasts)
  - Adopted children or children placed for adoption;
  - Foster children and/or children under legal guardianship;
  - Adopted children of children placed for adoption with your Spouse or Domestic Partner who reside with you the majority of the time;
  - Foster children and/or children under legal guardianship of your Spouse or Domestic Partner, if guardianship is not temporary, who reside with you the majority of the time;
  - Other children who qualify as federal tax dependents; and
  - Children for whom a Qualified Medical Child Support Order (QMCSO) has been issued by a U.S. court or state agency.
- "Spouse" means a person who is lawfully married under any state law to the enrolling Employee, including common law marriages that are registered with the appropriate public official.
- "Domestic Partner" means a person of the same sex or opposite sex who meets the following eligibility requirements:
  - You and your partner have registered your partnership with a state or local government that accepts such registrations; or
  - You and your partner satisfy the following criteria for the preceding twelve (12) months:
    - Be each other's sole domestic partner and intend to remain so indefinitely;
    - Reside together in the same principal residence and intend to remain so indefinitely;
    - Be emotionally committed to one another, share joint responsibilities for common welfare, and be financially interdependent;
    - Each be at least age eighteen (18) and mentally competent to consent to a contract;
    - Not be related by blood closer than would bar marriage under applicable law in effect where the employee and partner reside; and
    - Not be legally married to anyone else or involved in any other domestic partnership.
    - There have been at least twelve (12) months since the termination of a previous domestic partner.

Please note that the Plan Administrator has the sole right to determine who is eligible for health and welfare benefits under the Plan and may require documentation proving a dependent's status. If you are unable to provide the required documentation, your dependent will not be eligible for benefits under the Plan. In addition, you may be required to reimburse the Company for any costs associated with covering an individual who is not an eligible dependent, and your, as well as your dependent's (or dependents'), coverage may be terminated.

NOTE: Any attempt to enroll an ineligible dependent is considered a material misrepresentation and evidence of fraud on the Plan. If you enroll a dependent who is not eligible, that dependent's coverage may be dropped retroactively without any refund of premium payments if it is determined, in the Plan Administrator's sole discretion, that you fraudulently enrolled that person, or made a material misrepresentation of fact in connection with their enrollment.

State Eligibility Laws and ERISA

States sometimes pass laws that require employee benefit plans to provide benefits to individuals who otherwise are not eligible. For example, a state might require an employer to provide benefits to an ex-spouse or a child who exceeds the Plan's age requirements.

However, the Plan is governed by a federal law known as the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which supersedes any state law. As such, a state's eligibility laws do not apply to the Plan and will not govern the rights of your dependents to benefits under the plan. The Claims Administrators will rely upon the Company and the Plan Administrator to determine whether or not a person meets the definition of a dependent to be eligible for benefits under the Plan. This determination will be conclusive and binding upon all persons for the purposes of the Plan.

Federal Tax Implications for Dependent Coverage

Benefits for your Spouse and your eligible Children are excluded from your federal income. For other enrolled dependents, such as a Domestic Partner and/or their child(ren) (who are not also your Children), their coverage under this Plan is excludable from your income only if you claim that individual as your dependent for federal income tax purposes. If you enroll an individual in the Plan who does not meet the definition of a dependent under Code Section 152, such as a Domestic Partner or the child(ren) of your Domestic Partner who are not also your Child(ren), their coverage is taxable to you as income.

The Company will assume that all dependents, other than a Domestic Partner and the Domestic Partner's child(ren), are your tax dependents under Code §152. If you enroll a Domestic Partner and their child(ren), you must certify to the Plan Administrator whether they are your federal tax dependents.

The Company cannot advise you on whether your Domestic Partner and their child(ren) are your tax dependents. If you have questions concerning your specific situation, you should consult your own tax advisor.

Enrollment/Effective Date of Your Coverage

The Plan Year runs from January 1 through December 31.

When Coverage Begins

Generally, full-time salaried employees can participate in the Plan on the first day of the month following date of hire except as noted in the "*Your Flexible Spending Accounts*" section to this SPD, if enrollment is completed within the first thirty (30) days of employment during the initial enrollment period.

Full-time hourly employees who have been employed by the Company for ninety (90) days become eligible to participate in the Plan, and coverage begins on the ninety-first (91st) day if enrollment is completed within the first thirty (30) days of employment during the initial enrollment period.

Part-time employees who change to a full-time salaried position can receive coverage beginning on the first day of the month following the date they changed from part-time to full-time if enrollment is completed within the first thirty (30) days of the change in position.

Part-time employees who change to a full-time hourly position can receive coverage on coverage will begin on the later of:

- The ninety-first (91st) day of employment (including both part-time and full-time service); or
- The first day of the month following the date of change from part-time to full time if enrollment is completed within the first thirty (30) days of the change in position.

You must notify the Plan Administrator in a timely manner of your intent to enroll in the Plan (*see the Annual Enrollment materials to determine when you are eligible for benefits*). The Plan Administrator will provide the appropriate information for your enrollment in the Plan.

Initial Enrollment

Some health and welfare benefits are automatically provided to you under the Plan at no cost to you and without you needing to enroll in them. Please refer to the Annual Enrollment materials to determine which benefits are automatically provided to you when you become an eligible employee.

You must affirmatively enroll in the Plan to be covered under the health benefits and certain other benefits as specified in the Annual Enrollment materials. If you do not enroll during the initial open enrollment period, you will automatically waive coverage under all benefit options under the Plan.

To enroll yourself and/or your eligible dependents, you must enroll within thirty (30) days of your first day of employment. If you do not enroll at this time, you may enroll during the next open annual enrollment period, or special enrollment period, or if you have a qualified change in status event before the next open annual enrollment period. *See the "Changing Your Coverage" section.*

Information regarding enrollment procedures will be provided to you by the Plan Administrator. When you enroll your eligible dependents, you will need to provide relevant documentation as requested by the Plan Administrator.

As a Rehired Employee

If you terminate your employment, and are rehired by the Company, you must enroll again in the Plan to receive benefits. If you are rehired with less than a thirteen (13)-week break in service, you may be eligible for health coverage effective on the date you were rehired.

If you were full-time when you terminated employment and are rehired full-time, and your period of termination is:

- Less than thirty (30) days, your previous elections are reinstated at the same level (e.g., Associate v. Associate plus) as of the first of the month following the rehire date;
- More than thirty (30) days, you will be treated like a new employee.

Annual Enrollment

If you choose to change your benefit elections during the annual open enrollment period, your new elections will become effective on January 1 of the following Plan Year. If you do not enroll during Annual Enrollment, your participation in the benefit package options you elected in the prior Plan Year will continue to apply, except that your participation in the Health FSA will end, and you will not be eligible to make HSA contributions through the Plan. If you need to make an election change after the open annual enrollment period, you may change your elections during the next open annual enrollment period, a special enrollment period, or if you have a qualified change in status. *See the "Changing Your Coverage" section.*

Information regarding enrollment procedures will be provided to you by the Plan Administrator.

Effective Date of Your Coverage

New Employees

Generally, you and your dependents will become covered under the Plan on the date set forth above, if you are actively employed on that date (*see the Annual Enrollment materials to determine when you are eligible for benefits*).

Current Employees

If you enroll or make an election change during the open annual enrollment period, participation for you and your dependents begins on the next January 1.

Changing Your Coverage During the Year

Once you enroll in or decline health and welfare benefits under the Plan, your election generally must stay in effect for the Plan Year. However, you can make changes during the year if you have a qualified change in status, a special enrollment right, or certain other changes in circumstance, **and** the terms of the Plan benefit program under which you seek to change your election allows the change.

Qualified Change in Status

A qualified change in status is a specific change in circumstance that affects your eligibility for benefits and coverage under the Plan. Changes in eligibility or coverage must be due to and consistent with the qualified change in status, which is any of the following:

- Your legal marital status changes. For example, you get married, divorced, or legally separated or your marriage is annulled.
- You have a baby, adopt, or have a child placed in your care for adoption.
- Your dependent dies.
- Your dependent gains or loses eligibility under the Plan.
- You or your dependent moves to a new place of residence outside of your present coverage area (for example for HMO coverage).
- You or your dependent has a change in employment status, such as:
  - Switching from full-time to part-time employment (or vice versa).
  - Beginning or ending employment (this provision does not apply if you are rehired within thirty (30) days).
  - Experiencing a strike or a lockout.
- Commencing or returning from an unpaid leave of absence.
- Changing your worksite to a location that offers different benefits than are currently available to you.
- For purposes of dropping coverage under a Medical/Prescription Drug Plan, your expected hours worked are reduced below thirty (30) hours per week, if you intend to enroll in other minimum essential coverage no later than the first day of the second month after you drop your coverage under this Plan.
- Any other “change in status” event as determined by the Plan Administrator and permitted within rules for the Flexible Benefits Plan.

Special Enrollment Rights

Under the special enrollment provisions of HIPAA, you may enroll in the Plan’s medical coverage during the Plan Year, even if you previously declined coverage. This right extends to you, your Spouse, and your eligible children (not including children of a Domestic Partner).

You may request special enrollment if you or your eligible dependent declined coverage under this Plan because you had other group health plan or health insurance coverage, and you or your eligible dependent subsequently loses that other coverage due to one of the following:

- You or your dependents’ COBRA coverage under another employer’s plan ends because you exhausted the maximum COBRA coverage period.
- You or your dependents lose (non-COBRA) coverage under another plan because:
  - Employer contributions to the plan stopped, or
  - Coverage ended due to loss of eligibility.

In addition, if you gain a new dependent during the Plan Year through marriage, birth, adoption, or placement for adoption, you may enroll the new dependent, as well as yourself and any other eligible dependents, in the medical plan.

You must request special enrollment within thirty (30) days of the date of marriage, birth, adoption, placement for adoption or loss of other coverage. In the case of marriage, coverage will become effective on the first day of the month following your timely request for enrollment. For birth, adoption, or placement for adoption, coverage will become effective on the date of birth, adoption, or placement for adoption.

Medicaid/CHIP Special Enrollment Events

You will also be eligible to enroll yourself and eligible dependents during a Plan Year if either of the following occur:

- You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
- You or your dependent becomes eligible for Medicaid or CHIP premium assistance.

You must request special enrollment within sixty (60) days from the date of the Medicaid/CHIP event. Coverage will become effective on the first day of the month following your timely request for special enrollment.

Revocation of Election due to Enrollment in Qualified Health Plan

You can revoke a coverage election with respect to coverage under the Plan's medical benefits due to your enrollment in a Qualified Health Plan through a Marketplace if you satisfy the following conditions:

- You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;

AND

- The revocation of the election of coverage under the Plan's medical benefits corresponds to your intended enrollment for yourself and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Other Changes in Circumstance

Certain other events also permit you to change your election for coverage during the year. Your requested election change must be consistent with the event:

- You take a leave of absence under the Family and Medical Leave Act (FMLA).
- You experience a significant change in cost of benefits or coverage. (If there is an insignificant change in the cost of your benefits, your election will be adjusted automatically.)
- Your coverage is significantly curtailed.
- Your benefit option is significantly improved or a new benefit option is added.
- A QMCSO requires you or another individual to provide health benefits for a dependent.
- You or your dependent loses certain other group coverage sponsored by a governmental or educational institution.
- You or your dependent becomes eligible for Medicare or Medicaid.
- The enrollment period of another plan – for example, your spouse's – is different from the Company's open enrollment period.

How to Make Changes During the Year

You can report your mid-year change to the Plan Administrator. However, you must submit the required documentation of your election change event within thirty (30) days (sixty (60) days if due to Medicaid or CHIP-related events as described above under Special Enrollment) in order to make the change. If you do not report your mid-year change and provide the required documentation within the thirty (30)-day or sixty (60)-day period, you will not be able to make changes until the next annual open enrollment period, unless you again meet one of the conditions for an election change during the year.

Continuing Coverage

Uniformed Services Employment and Re-Employment Rights Act

The Uniformed Services Employment and Re-employment Rights Act of 1994, as amended ("USERRA"), sets requirements for continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to health coverage (medical/prescription, dental, vision, health FSA, and EAP) for you and your dependents.

Your non-health benefits under the Plan may be continued during USERRA leave and/or reinstated upon your return from USERRA leave, in accordance with the terms of each benefit option and the Company's military leave policy.

Continuation of Coverage

For leaves of less than 31 days, health coverage will continue, but you must make employee contributions for your coverage to continue. For leaves of 31 days or more, you may continue health coverage for yourself and your dependents as follows:

- You may continue coverage by paying the required contributions to the Company, until the earliest of the following:
  - Twenty-four (24) months from the last day of employment with the Company.
  - The day after you fail to return to work.
  - The day the Plan terminates.
- The Company may charge you and your dependents up to one hundred and two percent (102%) of the total cost.

Reinstatement of Benefits

If your health coverage ends during the leave of absence because you do not elect coverage under USERRA and you are reemployed by the Company, health coverage for you and your dependents may be reinstated if:

- You gave the Company advance written or verbal notice of your military service leave.
- The duration of all military leaves while you are employed with the Company does not exceed five (5) years.

You and your dependents will be subject to only the balance of a waiting period, if appropriate, that was not yet satisfied before the leave began. However, if an injury or illness occurs or is aggravated during the military leave, full plan limitations will apply.

If your health coverage under this Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active-duty service commences, these reinstatement rights will continue to apply.

Family and Medical Leave Act

Your health coverage will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended ("FMLA").

Benefits Coverage While on FMLA Leave

The Company will continue your health coverage under the Plan during your FMLA leave just as if you were still working. You are responsible for paying your normal contribution toward the cost of your health coverage during an FMLA leave. If your FMLA leave is unpaid, you must make all required employee contributions on an after-tax basis. If you do not pay your required contributions, your coverage may be terminated for non-payment, subject to reinstatement upon your return from FMLA leave.

Any newly-acquired dependent is eligible for coverage while your coverage is continued during an FMLA leave. (Refer to the Special Enrollment section of this SPD.)

Continued coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health coverage under the COBRA continuation rules. *See the "COBRA Continuation Rights" section for more details.*

Reinstatement of Canceled Coverage Following FMLA Leave

Upon your return to your employment following an FMLA leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period, if appropriate, to the extent that they had been satisfied prior to the start of the FMLA leave.

If Company Changes Benefits

If the Company offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but your contributions for these benefits may increase.

Contact the Plan Administrator for more details about the Company policy on other leaves of absence.

Termination of Coverage

Employees

Your coverage under the Plan will cease when any one of the following events described below occurs:

- You terminate employment (in which case participation shall cease in accordance with the terms of Incorporated Documents, individual plans, programs, insurance contracts, and benefit components).
- You cease to be an employee who is eligible for coverage.
- If participant contributions are required, you cease making contributions to the Plan.
- One or more benefits under the Plan are terminated by action of the Company.

Dependents

Coverage for your dependents will cease when any one of the following events described below occurs:

- Your (the Employee's) coverage terminates.
- A dependent ceases to qualify as a dependent.
- One or more benefits under the Plan are terminated by action of the Company.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively.

Continuation of Coverage

When coverage ends, you and/or your dependents may be eligible to continue health benefits under COBRA. *See the "COBRA Continuation Rights" section for more details.* You may also have the right to apply for individual coverage for certain benefits. *See the incorporated documents for more information.*

Coverage Continuation Rights Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), created the right to continue health coverage in certain circumstances.

COBRA coverage is a temporary continuation of health (e.g., medical, dental, vision, health flexible spending account, wellness and EAP) coverage when it otherwise would end because of a "qualifying event." After a qualifying event, COBRA coverage must be offered to each "qualified beneficiary." You, your Spouse, and your dependent Children could become qualified beneficiaries if you have health coverage under the Plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any Children born to you or placed for adoption with you during the COBRA continuation period.

Domestic Partners and Children

Although COBRA does not recognize Domestic Partners as qualified beneficiaries, the Plan will offer COBRA-equivalent coverage to your Domestic Partner, on the same basis as if your Domestic Partner was your Spouse. Therefore, your Domestic Partner could become eligible for COBRA-like coverage if you are enrolled in health coverage under the Plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Dependent children of a Domestic Partner can be qualified beneficiaries as dependents.

COBRA Qualified Beneficiaries

- Employee. You become a COBRA qualified beneficiary if you lose your health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than your gross misconduct.
- Spouse or Domestic Partner. Your Spouse or Domestic Partner becomes eligible for COBRA coverage if he or she loses health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your Spouse.
  - You terminate your domestic partnership.
  - You enroll in Medicare benefits (under Part A, Part B or both).
- Dependent Children. Dependent Children become eligible for COBRA coverage if they lose health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your Spouse.
  - The Child loses eligibility for coverage as a "dependent child" under the Plan.
  - You enroll in Medicare benefits (under Part A, Part B or both).

Note in the "*How Long COBRA Coverage Lasts*" section, the provisions regarding "Disability Extension of 18-Month Period of COBRA Coverage" and "Second Qualifying Event Extension of 18-Month Period of COBRA Coverage" are not applicable to these individuals.

When COBRA Coverage Is Available

The Plan offers COBRA coverage to qualified beneficiaries and non-qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment, the reduction in your work hours, or your death, the Company will notify the Plan Administrator of the qualifying event.

For other qualifying events (your divorce or legal separation or a dependent Child losing eligibility for coverage as a dependent Child) or the occurrence of a second qualifying event, you or your qualified beneficiary or non-qualified beneficiary must notify the Plan Administrator within sixty (60) days after the later of the date the qualifying event occurs or the day you lose coverage because of the qualifying event. If you or your qualified beneficiary or non-qualified beneficiary fails to notify the Plan Administrator within sixty (60) days after the qualifying event, then your dependent will not be entitled to elect COBRA coverage.

How COBRA Coverage Is Offered

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage is offered to each qualified beneficiary and each non-qualified beneficiary.

You may elect COBRA coverage on behalf of your spouse or domestic partner, and parents may elect COBRA coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary or a non-qualified beneficiary eligible to elect COBRA coverage) maintain a current address with the Plan Administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your eligible dependents have sixty (60) days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect COBRA coverage. If you fail to elect COBRA coverage within the applicable time frame, then you will lose the opportunity to continue coverage under COBRA.

How Long COBRA Coverage Lasts

COBRA coverage is a temporary continuation of coverage. It lasts for up to a total of thirty-six (36) months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent Child losing eligibility as a dependent Child.

COBRA coverage generally lasts for up to a total of eighteen (18)-months when the qualifying event is the end of your employment or reduction of your work hours. This eighteen (18)-month period of COBRA coverage can be extended in two ways:

Disability Extension of 18-Month Period of COBRA Coverage

If your eligible dependent covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the Plan Administrator in a timely fashion, you and all other eligible dependents may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months, if all of the following conditions are met:

- Your COBRA qualifying event was your termination of employment or reduction in work hours.
- The disability started at some time before the sixtieth (60th) day of COBRA coverage and lasts at least until the end of the eighteen (18)-month period of COBRA coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within sixty (60) days of receipt of the notice and before the end of the initial eighteen (18) months of COBRA coverage.
- An increased premium of one hundred fifty percent (150%) of the monthly cost of coverage is paid, beginning with the nineteenth (19^{th}) month of COBRA coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Coverage

If another qualifying event occurs during the first eighteen (18) months of COBRA coverage, your eligible dependents can receive up to eighteen (18) additional months of COBRA coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your Spouse and any dependent Children receiving COBRA coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both); get divorced or legally separated, or your dependent Child is no longer eligible under the Plan as a dependent Child, but only if the event would have caused your Spouse or dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the eighteen (18) months before the qualifying event, COBRA coverage for your dependents will last up to thirty-six (36) months after the date you became enrolled in Medicare. Your COBRA coverage will last for eighteen (18) months from the date of your termination of employment or reduction in work hours.

Other coverage options besides COBRA Continuation Coverage

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

For more information visit https://www.medicare.gov/medicare-and-you.

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-can-i-sign-up-for-medicare.

of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a forty-five (45)-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the twenty-fifth (25th) of the month preceding the next coverage period, but there is a thirty (30)-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

If you or your dependent elects COBRA coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- You or your dependent's coverage is effective as of the first day of the month following the qualifying event; however, if you waive COBRA coverage and then revoke the waiver within the sixty (60)-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
  - During the Plan's open annual enrollment period.
  - If you have a mid-year change in status.
  - If you have a change in circumstance recognized by the Internal Revenue Service ("IRS").
- You may enroll any newly-eligible Spouse or Child under Plan rules.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another health plan not offered by the Company.
- You or your covered dependent fails to make contributions by the due date as required.
- The Company stops providing health benefits to any employee.

COBRA coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Special Rules for Health Care Flexible Spending Accounts

For a Health FSA, COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA continuation coverage for the Health FSA cannot be extended beyond that time for any reason.

> *EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to*

participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any filing deadlines or other rules for filing a request for reimbursement under the Health Care FSA, as described earlier in this SPD, will continue to apply if you elect continuation coverage under the Health Care FSA.

Disagreements about the payment of Plan benefits can arise. The Company has formal appeal procedures in place for the Plan under the Employee Retirement Income Security Act of 1974 ("ERISA").

Eligibility and Enrollment Claims

All claims regarding your eligibility and enrollment for benefits under the Plan are determined by the Plan Administrator for the PetSmart SmartChoices Benefit Plan, in its sole discretion. If you have a question regarding your eligibility for benefits under the Plan, or your enrollment in the Plan, contact PetSmart Benefits Center at 1-866-263-8411 or HRSharedServices@petsmart.com.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and, for certain medical benefits, the applicable requirements of regulations issued under federal health care reform law and should be interpreted accordingly. If there is any conflict between this SPD and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For the Plan's insured benefits, the insurer's claims procedures will apply instead of the claims procedures described in this SPD, provided they are consistent with ERISA. The insurer's claims procedures are described in the benefits booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

To receive Plan benefits, you must follow the procedures established by the applicable Claims Administrator, which has the responsibility for making benefit payments. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Initial Claims

Initial claims for Plan benefits are made to the applicable Claims Administrator who is responsible for administering that benefit. The remainder of these procedures uses the term "Reviewer" to refer to the Claims Administrator that is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent otherwise permitted for urgent care claims, as described below), to the Reviewer. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, vision, Health FSA, and EAP coverage.)

- ***Non-Health and Non-Disability Benefit Claims.***

  For any claim that is not a health claim or a disability claim, the Claimant will be notified within ninety (90) days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the ninety (90)-day period stating that special circumstances require an extension of the time for decision, in which case the extension will not extend beyond one hundred eighty (180) days after the day the claim is filed.

- ***Health Benefit Claims.***

  - Urgent Care Claims**.** If a claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the Plan's receipt of

the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

If any person fails to follow the Plan's procedures for submitting an urgent care claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Plan Administrator or Reviewer will notify the potential Claimant, as soon as reasonably possible but no later than twenty-four (24) hours after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting the claim. The notification may be oral unless written notice is requested by the Claimant.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

- Pre-Service Health Benefit Claims. For a pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within fifteen (15) days after the Plan receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond thirty (30) days after receiving the claim. However, if an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

  If any person fails to follow the Plan's procedures for submitting a pre-service health benefit claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Plan Administrator or Reviewer will notify the potential Claimant, as soon as possible but no later than five (5) days after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting a pre-service claim. The notification may be oral unless written notice is requested by the Claimant.

  A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- Post-Service Health Benefit Claims. For a post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within thirty (30) days after the Reviewer receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time of making its decision beyond forty-five (45) days after receiving the claim. However, if such an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

  A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

- Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by plan amendment or termination) before the approved time period or number of treatments will constitute an adverse initial benefit determination. These determinations will be known as "concurrent care" decisions. The Reviewer will notify the Claimant of the adverse concurrent care decision at a time sufficiently in advance of

the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after the Plan receives the claim, provided that any such claim is submitted to the Plan at least twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments.

- ***Disability Benefit Claims.***

  If a claim for disability benefits is denied, in whole or in part, the Claimant will receive a written notice from the Reviewer within a reasonable period of time, but not later than forty-five (45) days after it receives the claim. Under special circumstances, the Reviewer may take up to an additional thirty (30) days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial forty-five (45)-day period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. If, prior to the end of the first thirty (30)-day extension period, the Reviewer determines that an additional extension is necessary due to matters beyond its control, the Reviewer may take up to an additional thirty (30) days to review the claim. If an additional extension of time is required, the Claimant will be notified before the end of the initial thirty (30)-day extension period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. If the Reviewer extends its period of reviewing a claim due to special circumstances, the notice of extension the Claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve those issues. The Claimant has at least forty-five (45) days within which to provide the specified information.

Manner and Content of Denial of Initial Claims.

- ***All Benefit Claims.***
  - If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:
    - The specific reasons for the denial;
    - A reference to any plan provision or insurance contract provision upon which the denial is based;
    - A description of any additional information that the Claimant must provide in order to perfect the claim and an explanation of why such additional material or information is necessary;
    - A statement that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
    - If applicable, a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following any denial on review of the initial denial; and
    - A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to ERISA Regulations Section 2560.503-1(m)(8).
- ***Health and Disability Benefit Claims.***

  In addition, for a denial of health benefits or disability benefits, the following will be provided:
  - A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

- If the adverse determination is based on medical necessity requirement, experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the Claimant's medical circumstances or a statement that restriction will be provided upon request and without charge.

- ***Health Benefit Claims.***

  For an adverse determination concerning an urgent care health claim, this information will include a description of the expedited review process and may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification is furnished not later than three (3) days after the oral notification.

- ***Disability Benefit Claims.***

  In addition to the requirements described above for health and disability benefit claims, the following provisions apply to disability benefit claims made under the Plan:

  - If a Reviewer denies a disability claim, the written or electronic notice provided to the Claimant shall also include the following information:

    - A discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination; and a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and

    - A statement that, prior to issuing any Adverse Determination on review of a disability benefit claim:

      The Plan Administrator shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided (as described in Disability Benefit Claims above) to give the Claimant a reasonable opportunity to respond prior to the date; and

      If such Adverse Determination is based on a new or additional rationale, the Plan Administrator shall provide the Claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided under the Disability Benefit Claims section above to give the Claimant a reasonable opportunity to respond prior to that date.

Review Procedures

- ***Non-Health and Non-Disability Benefit Claims.***

  A request for review of a denied claim for a benefit other than health or disability benefits must be made in writing to the Reviewer within sixty (60) days after receiving notice of denial. The decision on review will be made within sixty (60) days after the Reviewer receives the request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after the request for review is received. A notice of such an extension must be provided to the Claimant within the initial sixty (60)-day period and must explain the special circumstances and provide an expected date of decision.

  The Reviewer will afford the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

- ***Health Benefit Claims.***

  A request for review of a denial of an initial claim for health benefits must be submitted in writing to the Reviewer no later than one hundred eighty (180) days after the Claimant receives the notice of denial of the initial claim.

  Following a denial of an initial urgent care health benefits claim, the Claimant may request an expedited review of the claim and such a request may be submitted orally or in writing at the discretion of the Claimant. If an expedited review is requested, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Reviewer and the Claimant by telephone, facsimile or other available similarly expeditious method, whenever possible.

  In addition to providing the Claimant the right to review documents and submit comments as described for non-health and non-disability claims above, a review of a denial of a health benefits claim will meet the following requirements:

  - The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.
  - The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who was not consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.
  - The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.
  - For any Medical Plan option, the Plan will allow a Claimant to review the claim file and to present evidence and testimony as part of its internal claims and appeals process.
  - For any Medical Plan option, the Plan or Insurer will comply with the following requirements:
    - The Plan or Insurer will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or Insurer in connection with the claim as soon as possible and sufficiently in advance of date on which the notice of final internal adverse determination is required to be provided (as described in these claims procedures and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date; and
    - Before the Plan or Insurer issues a final adverse determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse determination is to be provided (as described in these claims procedures and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date.

- ***Disability Benefit Claims.***

  A request for review of a denial of an initial claim for disability benefits must be submitted in writing to the Reviewer no later than one hundred eighty (180) days after the Claimant receives the notice of denial of the initial claim. The request must be submitted in writing and must include:

  - the reasons why the Claimant feels the claim is valid; and
  - the reasons why the Claimant feels the claim should not be denied.
  - Documents, records, written comments and other information in support of the appeals should accompany the request.

This information will be considered by the Reviewer in reviewing the claim. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. The Reviewer will review the claim without granting any deference to the initial decision regarding the claim. Also, no Reviewer may be a person who was involved in making the initial decision regarding the claim or subordinate to that person. If the claim was based in whole or in part on a medical judgment, the Reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; this person will not be a person or a subordinate of a person consulted by the Reviewer in deciding the initial claim.

Deadline for Review Decisions

- ***Urgent Health Benefit Claims.***

  For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan receives the Claimant's request for review of the initial adverse determination.

- ***Other Health Benefit Claims.***

  - For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than thirty (30) days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.
  - For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than sixty (60) days after the Plan receives the Claimant's request for review of the initial adverse determination.

- ***Disability Benefit Claims.***

  The Reviewer will notify the Claimant of its decision on the appeal within forty-five (45) days after receipt of the appeal. Under special circumstances, the Reviewer may take up to an additional forty-five (45) days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified in writing before the end of the initial forty-five (45)-day period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The Claimant has at least forty-five (45) days to provide the specified information.

Manner and Content of Notice of Decision on Review

- ***All Benefit Claims***

  - Upon completion of its review of an initial adverse determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:
    - A description of its decision;
    - A description of the specific reasons for the decision;
    - A reference to any relevant plan provision or insurance contract provision on which its decision is based;
    - A statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
    - If applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a).

- ***Health and Disability Benefit Claims***
  - In addition, for any adverse determination on review of health benefits or disability benefits, the following must be provided:
    - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and
    - If the adverse determination on review is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that an explanation will be provided without charge upon request.
    - Also, upon request, the Reviewer will provide the Claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.
- ***Disability Benefit Claims***

  In addition to the requirements described above, the Reviewer will provide the Claimant written or electronic notice of its decision on review that will include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and
  - Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
  - In the case of an adverse determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

Adverse Determination

An Adverse Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a Plan option, and including, with respect to any group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. For purposes of any medical plan option, Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission. For purposes of disability benefits, an Adverse Determination also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Avoiding Conflicts of Interest

For claims involving medical plan coverage, the plan or Insurer will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for a claim for non-urgent care health benefits, the period for making the determination will be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds or, if earlier, until forty-five (45) days from the date the Claimant receives (or was reasonably expected to receive) the notice requesting additional information.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action with respect to any claim for benefits under the Plan (unless the Plan fails to follow those procedures).

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than twelve (12) months after the final review/appeal decision by the Reviewer has been rendered (or deemed rendered).

Voluntary External Review

If a Claimant is enrolled in a Medical Plan option that is not subject to a State external review process, then upon exhausting the Plan's internal claim and appeal procedures (or earlier, if the Claimant is deemed to have exhausted such procedure due to the Plan's failure to comply with the procedure) the Claimant may request external (i.e., independent) review of any claim that involves:

- medical judgment (including, but not limited to, those based on the Plan's or Insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational,
- a rescission of coverage,
- a determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program,
- a determination whether the Plan or Insurer is complying with the nonquantitative treatment limitation provisions of Section 712 of ERISA, or
- whether the Plan or Insurer is complying with the surprise billing and cost-sharing protections set forth in Sections 716 and 717 of ERISA.

The request for external review must be made within four months after the date the Claimant receives notice of an adverse benefit determination or final internal adverse benefit determination.

Within five (5) business days after receiving a Claimant's request, a preliminary review will be completed to determine whether:

- the Claimant is/was covered under the Plan;
- the denial was based on an issue involving medical judgment or a rescission of coverage (i.e., the claim does not relate to the Claimant's eligibility to participate in the Plan);
- the Claimant exhausted the Plan's internal claim and appeal process, if required; and
- the Claimant provided all information necessary to process the external review.

Within one (1) business day after completing the preliminary review, the Claimant will be notified in writing if his or her request is not eligible for an external review or if it is incomplete. If the Claimant's request is complete but not eligible, the notice will include the reason(s) for ineligibility and current contact information for the Employee Benefits Security Administration. If the Claimant's request is not complete, the notice will describe any information needed to complete the request. The Claimant will have the remainder of the four (4)-month filing period or forty-eight (48) hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, the Claimant's request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final external review decision within forty-five (45) days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will immediately cover the claim.

In addition, a Claimant has the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the Claimant's life or health or would jeopardize his or her ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
- Following a final internal adverse benefit determination involving:
    - a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the Claimant's life or health or would jeopardize his or her ability to regain maximum function; or
    - an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for expedited review.

HIPAA Privacy Rights

The HIPAA Privacy Rule applies to "Protected Health Information," which is defined as any written, oral, or electronic health information that meets the following three requirements:

- The information is created or received by a health care provider, the Plan, or the health carrier (i.e., covered entity).
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
  - Providing health care to you.
  - Your past, present, or future physical or mental condition.
  - The past, present, or future payment for your health care.

The Notice of Privacy Practices for the Plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information.

For more information regarding your rights with respect to Protected Health Information and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available from the applicable Claims Administrator.

Administrative Information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

Plan Name/Identification

The benefits described in this SPD are governed by the official plan documents. The official plan documents includes the certificates of insurance issued by insurers, benefits booklets issued by other Claims Administrators, this SPD, and other governing documents referenced herein.

The PetSmart SmartChoices Benefits Plan is an employer-sponsored welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA") and subject to the reporting and disclosure requirements of this law. PetSmart also sponsors the PetSmart LLC Flexible Benefits Plan, which is a "cafeteria plan" under Code Section 125 that allows you to pay for certain benefits under this Plan on a pre-tax basis. (Some benefits may require that you make after-tax contributions).

The plan number for the PetSmart SmartChoices Benefits Plan is: 501.

Plan Information

The SPD for this Plan includes this document and the incorporated documents listed in the "*Introduction*" section. In addition, you can get information about the Plan and your health and welfare benefits from enrollment materials and other general communications identified as containing Plan information. If the Company makes changes to the content of this document, it will send you a "summary of material modification" ("SMM") to notify you what has changed about the Plan. Any such SMMs shall be considered to be a part of this SPD.

Plan Employer/Plan Sponsor/Employer Identification Number

The employer/plan sponsor for the Plan is:

PetSmart LLC
19601 North 27th Avenue
Phoenix, AZ 85027
Telephone: 1-866-263-8411

PetSmart LLC's employer identification number is 94-3024325.

Participating Employers

There are no other Employers participating in the Plan at this time.

Plan Administrator

The Plan Administrator for the PetSmart SmartChoices Benefit Plan is:

PetSmart LLC
19601 North 27th Avenue
Phoenix, AZ 85027
Telephone: 1-866-263-8411
HRSharedServices@petsmart.com

COBRA Administrator

The COBRA administrator for the Plan is:

Alight Solutions
PetSmart Benefits Portal
digital.alight.com/petsmart
1-888-481-0101

Agent for Service of Legal Process

The agent for service of legal process under the PetSmart SmartChoices Benefit Plan is:

PetSmart, LLC
EVP, Human Resources
19601 North 27th Avenue
Phoenix, AZ 85027
Telephone: 1-866-263-8411

Plan Year

The Plan Year runs from January 1 to December 31.

Funding and Source of Contributions

The benefits under the Plan are funded by employer and employee contributions. The Company reserves the right to change the amount of required employee contributions for coverage under the Plan at any time, with or without advance notice to employees. Employer contributions are made from the Company's general assets. For the fully-insured benefits under the Plan, the Company pays a premium to an insurance company, from Company general assets and employee contributions, and the insurance company is responsible for providing coverage under the insured option.

Claims Administrators and Authority to Review Claims

Your eligibility for, and the provision of, health and welfare benefits, is determined by the Plan Administrator. The Plan Administrator has the full discretionary authority to interpret the Plan in accordance with its terms and the provisions of ERISA and determine eligibility under the Plan, including the discretionary authority to make factual determinations. The Plan Administrator has delegated its authority to make final claims determinations to the Claims Administrators. In some cases, the Claims Administrators may delegate this authority to certain other organizations on behalf of the Company. Benefits under the Plan are paid only if the Claims Administrators, or their delegates, decide in their discretion that the claimant is entitled to them.

The Claims Administrators' decisions are final and binding on all parties to the full extent permitted under applicable law.

No Employment Rights or Guarantee of Benefits

All terms of the Plan are legally enforceable. However, neither the Plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

Amendment/Termination

Although the Company presently intends to continue the Plan, it reserves the right to, at any time, change or terminate any and all health and welfare benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the entire Plan, or any part thereof, subject to applicable law. The procedures by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be amended or terminated are set forth in the Plan document, which is available for inspection and copying from the Plan Administrator. No consent of any participant is required to terminate, modify, amend, or change the Plan. Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any expenses incurred prior to the date that the Plan terminates. No extension of benefits or rights will be available solely because the Plan terminates.

Company's Right to Use Your Social Security Number for Administration of Benefits

The Company retains the right to use your and your dependents' Social Security numbers (SSNs) for benefit administration purposes and is required to obtain SSNs for tax and other reporting obligations to the IRS.

Your Rights Under ERISA

As a participant in the PetSmart SmartChoices Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and 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), if applicable, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, 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, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if this summary is applicable to the Plan.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD 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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report, if applicable, from the Plan and do not receive them within thirty (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, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), 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. or you can write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For more information about the Marketplace, visit **www.HealthCare.gov.**

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Appendix: Plan Contacts

Questions About Your Benefits?

For general questions about your benefits or enrollment, contact PetSmart Benefits Portal at **digital.alight.com/petsmart**, look for the "Need Help?" icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the PetSmart Benefits Portal. You can also call the PetSmart Benefit Center at 1-888-481-0101 from 8:00 a.m. to 5:00 p.m. PT Monday through Friday.

Here are the numbers to call and websites to visit if you have questions about your specific benefits. Please choose your provider.

Medical Benefits (including Behavioral Health, Mental Health and Substance Use Disorder) ***(see Kaiser below)***	***Form of funding***		
Aetna 1-855-496-6289 https://www.aetna.com	*Self-funded*	Anthem BC 1-844-424-8089 https://www.anthem.com/ca/	*Self-funded*
BCBS of Hawaii (HMSA) 1-800-651-4672 or 1-808-948-6121 https://members.hmsa.com/	*Fully-insured*	Cigna 1-855-694-9638 https://my.cigna.com	*Self-funded*
Dean / Prevea360 1-877-232-9375 http://aon.deanhealthplan.com/	*Fully-insured*	Geisinger 1-844-390-8332 https://www.geisinger.org/member-portal	*Fully-insured*
Health Net 1-888-926-1692 https://www.healthnet.com/myaon	*Fully-insured*	Medical Mutual 1-800-677-8028 before you are a member 1-800-541-2770 once you are a member https://member.medmutual.com	*Fully-insured*
Priority Health 1-833-207-3211 https://member.priorityhealth.com/login	*Fully-insured*	UnitedHealthcare 1-888-297-0878 http://myuhc.com	*Self-funded*
UPMC 1-844-252-0690 https://www.upmchealthplan.com/members/	*Fully-insured*		

If your Medical Plan is with Kaiser, please choose according to your region:

Medical Benefits with Kaiser (including Behavioral Health, Mental Health and Substance Use Disorder)	
Before you are a member: 1-877-580-6125 or https://www.kp.org	
Once you are a member, visit https://www.kp.org or choose your region to call:	
Kaiser – California *Fully-insured* 1-800-464-4000	Kaiser - Colorado *Fully-insured* 1-800-632-9700 (HMO) 1-855-364-3184 (Added Choice)
Kaiser – Georgia *Fully-insured* 1-888-865-5813 (HMO) 1-855-364-3185 (Added Choice)	Kaiser – Hawaii *Fully-insured* 1-800-966-5955
Kaiser – Mid-Atlantic States *Fully-insured* 1-800-777-9404 (HMO) 1-888-225-7202 (Added Choice)	Kaiser – Northwest *Fully-insured* 1-800-813-2000 (HMO) 1-866-616-0047 (Added Choice)
Kaiser – Washington *Fully-insured* 1-855-407-0900	

Prescription Drug Benefits	**Employee Assistance Program**
CVS Caremark *Self-funded* 1-855-821-0355	Optum Health Behavioral Services *Self-funded* 1-800-788-5614

Dental Benefits	
Aetna *Fully-insured* 1-855-496-6289 https://www.aetna.com	Cigna *Fully-insured* 1-855-694-9638 https://my.cigna.com
Delta Dental - AZ *Fully-insured* 1-844-266-7770 http://www.deltadentalaz.com/member/	DeltaCare USA Platinum *Fully-insured* 1-800-546-9751 before you are a member 1-800-471-8073 once you are a member http://www.deltadentalins.com
MetLife *Fully-insured* 1-888-309-5526 https://www.metlife.com/mybenefits	United *Fully-insured* 1-888-571-5218 https://www.myuhc.com

Vision Benefits	
EyeMed *Fully-insured* 1-844-739-9837 https://member.eyemedvisioncare.com/member/en	MetLife *Fully-insured* 1-888-309-5526 https://www.metlife.com/mybenefits
United *Fully-insured* 1-888-571-5218 https://www.myuhcvision.com	VSP *Fully-insured* 1-877-478-7559 https://www.vsp.com/signon.html

Life Insurance / Accidental Death & Dismemberment	Short-Term Disability / Long-Term Disability
New York Life *Fully-insured* 1-215-761-1000	New York Life *Fully-insured* 1-855-709-6395

Health Flexible Spending Account	Health Savings Account
Optum Bank *Self-funded* 1-866-243-5543 *by participant contributions*	Optum Bank *Individual accounts funded* 1-866-234-8913 *by participant contributions*

Voluntary Accident Injury / Critical Illness / Hospital Indemnity
MetLife *Fully-insured* 1-800-438-6388

Questions About Your Claim?

If you are submitting a claim, tracking a response, asking about a claims denial, how to appeal, or a decision on appeal, contact you Claims Administrator:

Medical Benefits Claims Administrators	
Aetna P.O. Box 14463 Lexington, KY 40512 1-855-496-6289	Anthem P.O. Box 54159 Los Angeles, CA 90054
Anthem (California only) P.O. Box 4310 Woodland Hills, CA 91365	Cigna P.O. Box 188011 Chattanooga, TN 37422
Dean Health Plan P.O. Box 56009 Madison, WI 53705 1-877-232-9375	Geisinger Quality Options Inc. Appeal Department 100 North Academy Avenue Danville, PA 17822 1-800-504-0443
Health Net Appeals and Grievance Department P.O. Box 10348 Van Nuys, CA 91410-0348 1-888-926-1692	HMSA Member Advocacy & Appeals P.O. Box 1958 Honolulu, HI 96805-8206 1-808-948-5090
Kaiser Foundation Health Plan, Inc. (California) P.O. Box 12923 Oakland, CA 94604-2923 1-800-464-4000	Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 1-303-338-3800
Kaiser Foundation Health Plan of Georgia, Inc, Nine Piedmont Center Atlanta, GA 30305-1736 1-404-364-4862	Kaiser Foundation Health Plan Inc, Hawaii Honolulu, HI 96813 1-800-805-2739

Medical Benefits Claims Administrators	
Kaiser Foundation Health Plan of the Mid-Atlantic 2101 East Jefferson Street Box 6233 Rockville, MD 20849-6233 1-301-468-6000	Kaiser Foundation Health Plan of the Northwest Members Relations Department Portland, OR 97232-2099 1-503-813-2000
Kaiser Foundation Health Plan Washington Options P.O. Box 34593 Seattle, WA 98124-1593 1-866-458-5479	Medical Mutual of Ohio Mail Zone: 01-4B-4809 P.O. Box 94580 Cleveland, OH 44101
Priority Health P.O. Box 232 Grand Rapids, MI 49501-0232 1-616-942-1221	UnitedHealthcare – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432
UPMC Health Plan Inc 600 Grant Street Pittsburgh, PA 15219 1-844-252-0690	

Prescription Drug Benefits Claims Administrator
CVS Caremark 1-855-821-0355

Dental Benefits Claims Administrator	
Aetna P.O. Box 14463 Lexington, KY 40512 1-800-451-7715	Cigna Dental P.O. Box 188044 Chattanooga, TN 37422 1-855-694-9638
Delta Dental Insurance Company P.O. Box 1809 Alpharetta, GA 30023	MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512

Vision Benefits Claims Administrators	
EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040	MetLife Vision Appeals P.O. Box 2350 Rancho Cordova, CA 95741 1-855-978-3937
UnitedHealthcare – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432	VSP 3333 Quality Drive Rancho Cordova, CA 95670 1-877-478-7559

For Claims Administrators for other benefits, contact information is provided in the "*Questions About Your Benefits?*" and in the summary materials provided by the Insurer.