Summary Plan Description in Effect January 1, 2024

The Government Employees' Benefit Association, Inc. (GEBA) Emergency Travel Benefit Plan (the "Plan") provides a benefit in the event that you or your spouse/domestic partner, or child dependent(s), (hereafter collectively referred to as "Plan Participant") must travel by airline or train to an immediate family member due to that person's sudden death or very serious injury/illness that places the family member in serious condition. A patient in serious condition is 1. acutely ill with an uncertain chance of recovery and 2. hospitalized in an acute or intensive care setting. Plan benefits are paid by GEBA, and the Plan is administered by GEBA. This Plan forms a part of the GEBA Group Benefits Plan which is the umbrella plan under which GEBA offers benefits to its membership.

The following is a brief description of the Plan presented in a question-and-answer format.

Q: What is the Emergency Travel Benefit Plan?

A: It's a benefit Plan that reimburses you for 80% of the cost of a round trip, coach, airline or train fare (maximum reimbursement of $1,500) from the Plan participant's location to an immediate family member, worldwide. The trip is covered providing that the Plan participant travels as the result of the sudden death, or the serious injury/illness of an immediate family member. Coverage is subject to the limitations described below and is more fully described in the governing Plan instruments which are available for your review at the GEBA office.

Q: Please define "serious injury/illness."

A: A serious injury/illness is defined as a medical condition which by customary practice of the medical profession warrants placing the patient in serious condition.

A patient in serious condition is

1. acutely ill with an uncertain chance of recovery, and .
2. hospitalized in an acute or intensive care setting.

Q: Who is eligible for this coverage?

A: Any Active or Special Member as defined in GEBA Bylaws.

Q: What are the available coverage options?

A: There are four coverage options: (1) plan participant for his/her immediate family, (2) plan participant for his/her immediate family and spouse/domestic partner for his/her immediate family, (3) plan participant for his/her immediate family as well as spouse/domestic partner's immediate family and spouse/domestic partner for his/her immediate family as well as plan participant's immediate family ("Cross Coverage"), and (4) coverage for natural, step, and adopted children up to age 26 of the plan participant and the spouse/domestic partner. Double coverage is prohibited.

Q: How does Child coverage work?

A: The eligible children can visit the member's immediate family or the spouse/domestic partner's immediate family. Eligible child(ren) also have coverage for visiting their own immediate family members who do not have relation to the participant or the spouse/domestic partner.

Q: Can I buy only dependent coverage?

A: NO. You must choose one of the other three options in order to add the dependent coverage.

Q: If I am married, why would I want to select option 3?

A: If you select option 1 and option 2 without option 3 and your spouse/domestic partner's father suffered a very serious illness, then your spouse/domestic partner would be able to use the Plan to reimburse his/her emergency travel expenses incurred to visit the parent, but it would not reimburse your expenses. If you select option 3, then you could be reimbursed for travel with your spouse/domestic partner to visit his/her parent.

Q: Who is an eligible child?

A: If option (4) is elected eligible children include the Plan participant's natural, step and adopted children to age 26 or unmarried dependent natural, step or adopted children (regardless of age) who are incapable of self-sustaining employment due to a physical or mental disability.

Q: What is meant by immediate family members?

A: Participant's spouse/domestic partner, parents, children, grandparents, grandchildren, brothers (and sister in-laws) and sisters (and brother in-laws). Adopted and step family members are also included. In-laws related to the spouse/domestic partner (if applicable) are only covered with "Cross-Coverage". Review the family inclusion chart for details.

Q: Can a plan member travel for their own illness or treatments?

A: No, this plan will not cover any travel related to the plan members' own illness or treatment plans.

Q: How much will I be reimbursed for travel covered under this Plan?

A: You will be reimbursed up to 80% of the actual round trip, economy or coach airline or train fare up to the maximum reimbursement of $1,500. (Air or train fares for which you are reimbursed by any government entity will not be covered by this Plan.) Round-trip travel must be to a single location. A scheduled stopover for more than 24 hours will be deemed as the destination.

In the event that economy seats are not available, or participant chooses seats in another fare class, GEBA will only reimburse up to 50% (up to $1,500 per covered plan participant) of the air or train fare and applicable taxes and fees.

Q: Are there pre-existing condition limitations?

A: Yes. If the immediate family member was hospitalized, received advice or treatment, or had a chronic condition diagnosed during the 12-month period immediately preceding the effective date of coverage (or the date on which you add the family member to your enrollment form, whichever is later) and your travel commences within 12 months following that date, the plan would not reimburse you for that trip. This plan does not cover trips to terminally ill immediate family members during the 12-month period following the effective date. A very serious sudden illness/injury or death resulting from any other condition would be covered. Any pre-existing condition would be covered after you have been enrolled in the Plan for 12 consecutive months. When utilizing the Plan Benefits to travel for a serious injury or illness, a signed physician's statement must indicate that it was recommended that you be in attendance at the time of or immediately following the decline in health. Travel for optional or scheduled surgeries are not covered.

Q: How many emergency trips can my spouse/domestic partner, if covered, and I be reimbursed for in any given year?

A: Each Plan member is permitted reimbursement for one round trip during a 12 consecutive month period. That is, 12 consecutive months must pass between claims.

Q: How do I enroll for Plan coverage?

A: To enroll for Plan coverage, you must complete a Plan enrollment form. These forms should be mailed upon completion to GEBA at 1362 Mellon Road, #100, Hanover, MD 21076 or via email to geba@geba.com. But remember, if you have other GEBA plans paid through payroll deductions, your payroll allotment will be combined for all the GEBA premiums you pay.

Q: What does this plan cost and how do I pay these premiums?

A: GEBA will charge you $3 per biweekly pay period ($78 annually) for each option selected. Each dependent child is charged $78 annually. GEBA reserves the right to adjust this premium rate each January 1. You may choose either the payroll allotment method, direct billing or automatic debit from a checking or savings account. The exact payment amount of the initial payment may be prorated based on your billing frequency and effective date. Please notify GEBA if your selected payment method changes.

Q: What happens if I miss a premium payment?

A: If your selected payment methods fails to make a payment to GEBA, GEBA will make attempt to receive payment either by automatic debit from a checking or savings account (if applicable) or send a bill. If you do not remedy the problem within 90 days of failed payment, GEBA will retroactively terminate your coverage to the failed payment date. We will notify you about the termination action. If you file a claim within 90 days of the failed payment, you must pay the total premium amount due before being eligible for claim disbursement. No benefits are payable if premium is more than 90 days overdue.

Q: When will my coverage become effective?

A: Your coverage will become effective on the first day of the month following GEBA approval of your enrollment form. You will be informed of the effective date of your coverage.

Q: How will I know when I am covered?

A: You will receive a confirmation letter from GEBA as evidence of coverage.

Q: What if I retire or resign, can I keep my coverage?

A: Yes, you can continue your Plan coverage as long as you want, regardless of retirement or resignation as long as you continue to pay your premium.

Q: Once I am covered, may I change options or add family members to my enrollment?

A: Yes, you may change options and/or add or delete plan participants by completing and submitting to GEBA a new Plan enrollment form. Of course, no change can be given retroactive effect and all additional family members will be subject to the pre-existing condition limitation described in this document and Plan instrument.

Q: Once I am covered, how do I file a claim?

A: Premium payments must be current before filing a claim. Covered travel must begin within 21 days from the date of the causal event (sudden death, serious injury, or the onset of the serious illness. We recommend calling the GEBA office prior to submitting your claim to discuss eligibility.

Within 90 days of completing travel, submit a completed claim form to GEBA with your airline, or train ticket receipts. In the case of injury or illness, a physician's statement attesting to the need for your trip must also be attached. A physician statement form is available on the GEBA website. In the event of a death, a copy of the death certificate must also be attached. Claims must be submitted within 90 days of travel.

Q: If GEBA approves a claim, to whom does it pay benefits?

A: Benefits will be paid to the participant regardless of who makes the covered trip. However, if the covered trip is for the death of the member participant, the benefit will be made to the spouse/domestic partner or estate of the member.

Q: How quickly are claims paid?

A: Claims are typically paid within 3 weeks. However, if the claim is incomplete, it will delay the claim processing procedures. GEBA will keep you informed.

Q: Can I take both the train and plane, and get reimbursed for both?

A: No, the reimbursement of 80% is for the one mean of transportation, either the air or train travel.

Q: What are reimbursable expenses?

A: GEBA will reimburse the cost of round-trip coach or economy (lowest travel class of seating) air or train fare ticket, applicable taxes, one checked bag, and applicable airport or train rail fees up to 80% (up to $1,500 per covered plan participant). GEBA will not reimburse airline points, travel insurance, change fees, airport transportation, or any other additional fees.

Q: What if the only air or train tickets available are for Premium Economy, Business Class, or First Class?

A: In the event that economy seats are not available, GEBA will reimburse up to 50% (up to $1,500 per covered plan participant) of the air or train fare and applicable taxes and fees.

Q: Can I be reimbursed for a rental car?

A: No.

Q: May I cancel this coverage at any time?

A: Yes, upon written notification to GEBA. However, cancellations may not be retroactive, and the termination date must coincide with the end of month. A refund will be provided should there be a credit on the account.

Q: Who pays the benefits provided under the Plan?

A: Benefits under this Plan are paid from GEBA's general assets. These assets are derived primarily from premiums from GEBA members and are held aggregately to pay benefits and group insurance premiums for the GEBA Group Benefit Plan (which encompasses this Plan) and reasonable administrative expenses. Although GEBA has no present intention to do so, it must inform you that it reserves the right to modify, suspend, or terminate this Plan at any time.

The following information about the plan is required to be furnished to you under the Provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended and implementing U.S. Department of Labor regulations. The evidence of coverage and this required information from your Summary Plan Description:

Plan Participants: The plan provides benefits for all members who have been approved for coverage.
Plan Sponsor: Government Employees' Benefit Association, Inc. ("GEBA"), 1362 Mellon Road, #100, Hanover, MD 21076, (410) 657-8060.
Employer ID Number: EIN #52-6051763
Plan Number: 501
Plan Administrator: The Plan is administered and maintained by GEBA, at the address listed above (see "Plan Sponsor").

Type of Administration: The Plan is administered by the Plan Administrator (GEBA), at the address listed above (see "Plan Sponsor'). The duty of the Plan Administrator is to see that the provisions of the Plan, including this program, are carried out for the benefit of the persons entitled to participate without discrimination among participants.

Amendment or Termination of Plan: This program and any other program under the Plan and the Plan itself may be amended or terminated at any time by GEBA. If the Plan is terminated, GEBA may use plan assets to pay benefits outstanding as of the later of the date the termination is adopted or is effective, and Corporation expenses. Any remaining assets will be allocated by a Board of Directors' resolution that conforms with applicable law and does not adversely affect the Code Section 501(c) (9) qualified status held by GEBA. If the Plan is merged with another plan or plan assets are transferred to another plan, plan assets will be allocated according to the merger or acquisition agreement's terms.

Agent for Service of Legal Process: National Registered Agents, Inc., 1090 Vermont Ave., N.W., Washington, D.C. 20005. Legal Process may also be served to GEBA's President & CEO, at the address listed above (see "Plan Sponsor").

Plan Year: All financial records of the Plan are kept on a fiscal year of January 1 through December 31.

Cost of Benefits and Plan Funding: Premiums for this program are paid by you, the Plan Participants. Benefits under this program are funded out of Plan assets.

Claim Procedure: Initial Decision of Claim: Time Limits on Decision: GEBA will inform a participant in writing of the decision on his/her claim within 90 days of the date the claim is filed or will provide a notice that explains the special circumstances that require a delay in decision.

Content of Denial Notice: If GEBA partially or wholly denies a claim, it will notify the participant in writing of the specific reason(s) for the denial. The notice will give a specific reference to the pertinent plan provision on which the denial is based and will describe any additional information required to make the claim valid. This decision will be final unless the participant appeals the decision following the procedures stated in the notice and described below.

Appeal of Denied Claim: How to Request a Review of a Denied Claim: A participant who wants to appeal a denied claim must send a written request for Board review of the claim denial to GEBA no later than 90 days after the date he/she receives the denial notice. The request must explain why the claim should have been approved. It may include additional factual material for Board consideration. A participant may review, upon

request, all available materials and plan documents which relate to the appeal. GEBA may make a reasonable charge for retrieving and copying such documents. If a request for review is not filed within the required 90-day period, the participant will lose the right to a claim review.

Decision on Review: Time of Decisions: GEBA usually will send the participant a written decision on his/her appeal within five days after the regularly scheduled Board meeting following its receipt of the review request.

Final Decision: The Board of Directors has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The Board's decision will not be overturned unless it is arbitrary and capricious.

Your Rights under ERISA

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

1. Receive Information About Your Plan and Benefits.
2. Examine, without charge, at the GEBA Office, all plan documents and copies of all documents filed by the plan with the U.S. Department of Labor, such as the latest annual reports (form 5500 Series) and plan descriptions. This examination may take place between the hours of 10 a.m. and 3 p.m. Monday through Friday, except holidays.
3. Obtain copies of these plan documents (including insurance contracts and the Series 5500 report) upon written request to the Board of Directors of GEBA who may make a reasonable charge for the copies.
4. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

If your claim for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to this 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 materials from the plan and do not receive them within 30 days, you may file suit in federal district court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits that are denied or ignored in whole or in part, you may file suit in a state or federal court. If the 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 federal court. The court will decide who should pay court costs and fees. If you lose, the court may order you to pay these costs and fees. For example, you may have to pay these fees if the court finds your claim to have been frivolous.

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about you rights under ERISA, or if you need assistance in obtaining documents from the plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.