Ameriprise Financial
Health & Wellness Benefits Plans Administration & Participation
2023 Summary Plan Description

248256 L (3/23)

Table of Contents

Participation

Who is eligible?

Employment classification

Each employee who satisfies the Health and Wellness Benefit Plans' eligibility requirements may be a participant. Your employment classification determines eligibility. You are eligible to participate in the Plans if you are:

- An employee who is classified as a regular full-time (30+ hours per week) employee or regular part-time employee (20-29 hours per week with a waiting period of 90 days) for Ameriprise Financial, Inc., and more than half of your income from the company is reported on Form W-2, regardless of whether the use of Form W-2 is subsequently determined to be erroneous;
- An employee who is classified as a regular full-time (30+ hours per week) employee or regular part-time employee (20-29 hours per week with a waiting period of 90 days) for an affiliated employer that participates in the Plans (Appendix C) and more than half of your income from the company is reported on Form W-2, regardless of whether the use of Form W-2 is subsequently determined to be erroneous; or
- An employee of an affiliated or subsidiary employer that Ameriprise Financial, Inc. designates as eligible to participate in the Plans.

You are not eligible to participate in the Health and Wellness Benefit Plans if more than half of your income from the company is reported on Form 1099.

Retirees

At retirement, you may convert your basic employee life insurance coverage, spouse/domestic partner life and dependent life insurance coverage in the amount of one times your covered pay to an individual policy through Metropolitan Life Insurance Company ("MetLife") at your own expense. In addition, you may continue employee supplemental life insurance coverage in excess of one times your covered pay, as well as any spouse/domestic partner life insurance coverage, in excess of one times covered pay, if applicable, through MetLife's portability option, also at your own expense.

Coverage effective dates

Your coverage effective date is dependent upon your employment classification and that your initial enrollment elections were made within 60 days from your date of hire or when you became eligible under the Plans.

Full-time employees

If you are a regular full-time employee of the company scheduled to work 30 or more hours per week, your effective date of coverage in the Health and Wellness Benefit Plans is your date of hire.

Part-time employees

If you are a regular part-time employee of the company scheduled to work at least 20 hours each week, you are eligible to participate in the Health and Wellness Benefit Plans after 90 days of service. Subsequent changes in your work hours may affect your eligibility for benefits.

Part-time employees that are residents of Hawaii

If you are a resident of Hawaii, you are eligible to participate in the Medical Plan once you have been employed for four weeks or more as a regular part-time employee or temporary employee and work at least 20 hours per week. Regular part-time employees in Hawaii are required to satisfy the 90-day waiting period to be eligible for all other benefits.

Initial enrollment

A link to the New Hire Benefit Enrollment Guide (the "Guide") will be e-mailed to you at work within 14 days of your hire date unless you attend an in-person new hire orientation. The Guide includes information on the different health and wellness benefits as well as instructions on completing your enrollment elections. If you have not received the Guide within 21 days from your date of hire, call the HR Service Center at 1.877.267.4748 to request a printed copy or link to the Guide.

You have 60 days from your date of hire or when you become benefits eligible to make your benefit elections.

After you have saved and submitted your elections in HR Direct, it is very important to review and print a confirmation of the coverage you've chosen. If you require further assistance, you have two weeks from when you submitted your elections to contact the HR Service Center. After this two-week period your elections are final and cannot be changed until the next open enrollment period, unless you experience a Qualified Event. For more information, see the "*Qualified Events*" matrix below.

Coverage becomes effective based on your specific employment classification as described above. Premiums will be deducted from your pay to cover any retroactive period of coverage based on the effective date of coverage. You must be actively at work on the day your coverage begins. If you are absent for any reason, coverage will begin on the day you start active employment with the company. We encourage you to make your elections early as it can take up to two weeks from the date you enroll in the Plans to produce any necessary ID cards or material. Enrolling early will also reduce the number of retroactive payroll deductions that you are required to pay.

Certain levels of life insurance and long term disability insurance will not be effective until proof of approval is provided by MetLife. See the applicable Summary Plan Descriptions ("SPDs") for details.

If you do not enroll within the 60-day period, the only health and wellness benefits coverage you will receive is basic life insurance coverage in the amount of one times your covered pay. No other health and wellness benefits coverage will be available for the remainder of the calendar year, unless you experience a Qualified Event that allows a change to your current elections. For more information, see the "*Qualified Event*" matrix.

Rehired employees

If your employment ends but you are rehired within 30 days from your termination date, the Health and Wellness Benefit Plans will be reinstated to those in effect at the time you left the company, with the exception of the purchased vacation days. If your employment ends and you return to work after 30 days or more from your termination date, you will be required to reelect benefits.

If your employment ends and you return to work within 12 months as a part-time employee, you will be given credit for time worked toward becoming eligible for benefits (e.g., if you worked for 45 days, you would only need to work an additional 45 days to be eligible for benefits).

Relocated employees

If you relocate during the year and experience a change in benefit plan options, you may change those options, within 60 days of the date you are relocated.

Eligible and ineligible dependents

You can choose coverage for yourself and your eligible dependents. For example, to cover a dependent under a specific Medical Plan option, you must first be enrolled yourself. If at any time your dependent ceases to meet the eligibility requirements, you must notify the HR Service Center within 60 days of the date your dependent becomes ineligible. If you fail to notify the HR Service Center within 60 days, your dependent will be dropped

from coverage, when notified, retroactive to the date on which they were no longer eligible and premium deductions will not be refunded beyond 60 days.

The following table summarizes eligible dependents:

	Eligible	Not eligible
Spouse/Domestic Partner	Your current legally married spouse as defined by United States federal law Your current common law opposite-gender spouse in a legally recognized common-law marriage Your domestic partner - a relationship between an Employee and one other person of the same or opposite sex. All of the following requirements apply to both persons: • They have lived together for at least six months. • They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside. • They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law. • They must be at least 18 years old. • They must share the same permanent residence and the common necessities of life. • They must be mentally competent to enter into a contract. • They must be jointly responsible for each other's common welfare and share financial obligations. .	Legally separated or divorced, even if you are court-ordered to provide health insurance. If spouse/domestic partner is an Ameriprise Financial, Inc. employee and also covered by Ameriprise Financial, Inc. benefits as an employee.

	Eligible	Not eligible

Natural-Born Child(ren) or Legally Adopted Child(ren) of you, your spouse/domestic partner, stepchildren who your spouse/domestic partner has legal custody or a dependent for whom you or your spouse/domestic partner has court appointed legal guardianship.	The child is yours, your spouse's/domestic partner's, natural-born child, legally adopted child, or has been placed in your home for adoption; and one of the following:
	• The child is under age 26, regardless of
	  • Marital status
	  • Place of residency
	  • Employment/Student status; or
	• The child is certified as a disabled dependent over age 26 and continues to be disabled, and you have completed the Statement of Disability Application and it has been approved by the Plan that your child meets the criteria of a disabled child dependent.
	
	The above list is not meant to be exhaustive.
		If your spouse/domestic partner is an Ameriprise Financial, Inc. employee and covers the same dependents under an Ameriprise Financial, Inc. benefits plan.
		
		If your dependent child is an employee of Ameriprise Financial, Inc. and is covered by Ameriprise Financial, Inc. as an employee.

You may not enroll or cover:

- Grandchildren
- Your parents
- Your ex-spouse, legally separated spouse, even if you are court-ordered to provide medical insurance coverage
- Any other person who does not meet the requirements for an eligible dependent as described in the table above
- Yourself as both an employee and dependent of an Ameriprise Financial, Inc. employee or children as both your dependents and your spouse's/domestic partner's dependents if your spouse/domestic partner is also an Ameriprise Financial, Inc. employee

If your covered dependent becomes ineligible at any time, you must notify the HR Service Center within 60 days of the date the dependent ceases to be eligible in order to preserve continuation rights under COBRA. Premiums will continue to be taken until you notify and provide any required documentation to the HR Service Center. Premiums paid prior to notification/documentation will only be refunded up to a maximum of 60 days or when notification is given, whichever is less. Dependents that are voluntarily dropped from benefits plan coverage during open enrollment are not eligible for COBRA continuation coverage.

Disabled dependent status verification

To continue a child's coverage once they reach age 26, you must certify the child's disability status when requested by the Plan. Coverage will be terminated if such proof is not provided within 60 days of the date of the written request. Coverage will not be eligible for reinstatement until the next open-enrollment period.

Audits of dependent status

Ameriprise Financial, Inc. and/or Claims Administrators reserve the right to conduct audits and review all dependent eligibility. You may be asked to provide documentation to verify your dependents' eligibility at any time. If you fail to comply, misrepresent or omit information, or if it is found that your dependent no longer meets the eligibility requirements, your dependent's coverage will be terminated retroactively. You may be required to repay all costs incurred by the Plan and it may be grounds for further disciplinary action up to and including termination of your employment. Premiums will not be refunded, and you may lose your right to continue coverage under COBRA.

Qualified Medical Child Support Order (QMCSO)

A dependent may also include any child whose coverage is required by a Qualified Medical Child Support Order ("QMCSO") under Section 609 of the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.

When coverage of a child is required by a child support order determined to be a QMCSO, the child will be enrolled, and the cost of dependent coverage will be deducted from your pay without regard to whether you request the coverage or authorize the deductions. You will be notified in writing if a QMCSO is received by the HR Service Center for your child.

Only medical child support orders received directly from a child support agency or a court will be accepted as a valid QMCSO. Agencies can submit their support orders to Ameriprise Financial, Inc., Human Resources – HR Service Center, 172 Ameriprise Financial Center, Minneapolis, MN 55474.

Cost

You and Ameriprise Financial, Inc. share the cost of health care coverage. A full contribution is deducted each paycheck for any period of time during the pay-period for which you are enrolled in coverage. This is not a "pro-rated" amount at hire date nor at termination of coverage. Employee contributions, for most plans, are paid on a before-tax basis, which lowers your taxable income. However, it also restricts your ability to change coverage mid-year. You may only change coverage mid-year under certain circumstances. For more information, see the section titled "*Changing Coverage*".

In addition, premiums differ between regular full-time and part-time employees. Any change in premium due to a change in status from full-time to part-time, or vice versa, becomes effective the date of the employment classification change. Contributions for your coverage will be deducted from your bi-weekly pay to cover the duration of your coverage, including premiums for retroactive coverage and premiums paid outside of 60 days from the date a dependent is no longer eligible. The amount you pay depends on the option you choose, your tobacco usage and who you cover. If you and/or your spouse/domestic partner are users of tobacco products, you will pay a surcharge on your bi-weekly contributions for the Medical Plan. If you cover a spouse/domestic partner who has coverage available to them through another employer, a bi-weekly surcharge will be added to your Medical Plan contributions. This charge does not apply when the other coverage is Medicare. The tobacco surcharge does not apply to employees in Hawaii.

Part-time employees who work less than 30 hours per week receive a lower level of company contribution for medical and dental coverage than full-time employees.

Your contributions to the Health Care Reimbursement Account, the Health Savings Account, Medical Plan, Dental Plan, Vision Care Plan, Dependent Care Reimbursement Account, Vacation Purchase Plan and supplemental insurance under the Life Insurance Plan are made on a before-tax basis. (If you live in Puerto Rico, all contributions are made on an after-tax basis.)

If you purchase spouse/domestic partner life insurance, child life insurance or accidental death and dismemberment ("AD&D") coverage under the Life Insurance Plan or elect to participate in the Long Term Disability Insurance Plan or the Legal Assistance Plan, you will pay for these benefits on an after-tax basis.

The Employee Assistance and Health Matters Programs of the Medical Plan, basic employee life insurance coverage under the Life Insurance Plan and the Severance Pay Plan are all provided at no cost to you.

Contributions for your coverage will be deducted from your pay to cover the duration of your coverage, including premiums for retroactive coverage.

How compensation is defined

Your benefits and cost for coverage (if any) for certain plans is determined based on your annual compensation and in some cases commission compensation. See *Appendix D* and *Appendix E* for compensation definitions. Because your next year's annual compensation data is not available at the time of open enrollment, cost information and coverage amounts for the following year for life insurance, AD&D and long term disability insurance are estimated based on your compensation as of a designated date (usually in September or October). If your compensation amount changes between the time you have made open-enrollment elections and when the following year's benefits become effective, actual costs and coverage amounts will replace the estimates and you may see a difference between your estimated costs and actual costs and estimated coverage levels and actual coverage levels for those benefits.

The cost for purchasing vacation days under the Vacation Purchase Plan is based on your compensation at the time of open enrollment. Unlike the costs and coverage amounts for life insurance, AD&D and long term disability insurance, the cost of purchasing vacation days will not change for the following year because your compensation for calculating these benefits is frozen as of the designated date. This means if your annual compensation increases following the date your compensation is frozen, the cost of purchasing vacation days will not increase for the following year. Conversely, if your annual compensation is reduced, the cost of purchasing vacation days will not decrease. In addition, if your employment status changes after open enrollment (for example moving from full-time to part-time or from part-time to full-time), your purchased vacation day election will not change and will be based on your status as of the designated date prior to open enrollment.

Note that severance pay benefits are determined by your covered pay under the terms of the plan; however, there is no cost to you for coverage as these benefits are company paid and do not require an open-enrollment election.

For the purposes of the Health and Wellness Benefit Plans, the "annual compensation" of regular full-time and part-time employees including corporate office staff is defined as covered pay. Covered pay does not include overtime, bonuses, shift differentials or any other compensation elements except for certain positions within Ameriprise Financial, Inc. such as Field Leaders and Financial Advisors. Field Leaders and Financial Advisors should refer to *Appendix D,* which details what components of variable compensation above level income (covered pay) are included in determining benefits under the various plans. Wholesalers should refer to

Appendix E, which details what components of compensation are included in determining benefits under the various plans.

Compensation elements that are not listed in the charts are expressly excluded from the definition of "annual compensation" for health and wellness benefit purposes.

Changing coverage

Your ability to make changes in your health coverage is restricted except during open enrollment for the next calendar year. After you enroll, you cannot cancel or modify coverage during the year unless you have a Qualified Event or become entitled to Special Enrollment Rights. For more information, see the "*Qualified Events*" and "*Special Enrollment Rights*" sections.

If you experience a Special Enrollment Right or Qualified Event, you may be able to change coverage mid-year provided that the change is consistent with the event you have experienced. You must make changes to benefits during the published open-enrollment period or within 60 days of an event that qualifies as either a Special Enrollment Right or Qualified Event.

In order to make any changes to your benefits, other than during the published open-enrollment period, you should log into HR Direct within 60 days of your Qualified Event and proceed with making changes by clicking on the "Benefits" icon and selecting "Change Benefits." If you are on a leave or do not have access to HR Direct, you should call the HR Service Center at 1.877.267.4748. If you are on leave, you have two options. You can call the HR Service Center at 1.877.267.4748. A representative will take your election(s) over the phone, provided the requirements spelled out in the preceding paragraph are met. Or, if you prefer, you can request a paper enrollment form be sent to you, which you must complete, sign and send back to the HR Service Center within 60 days of the Qualifying Event. You must take action by making the appropriate allowed change in HR Direct within those 60 days in order for the change to take effect.

If you fail to notify the HR Service Center within 60 days of a Qualified Event to drop a dependent, premium deductions and change in tax status will only be adjusted back the earlier of 60 days or to the beginning of the current tax year.

Once you make a change within those 60 days, you then have two weeks to contact the HR Service Center at 1.877.267.4748 to make any corrections to your election changes. After the two-week period, your decisions are final until the next open enrollment or until you experience another Qualified Event. All changes are effective the date of the event that allows the change to occur. For additional questions about changing coverage, call the HR Service Center at 1.877.267.4748.

Vacation Purchase Plan elections can only be made during the open-enrollment period, even if you have a Qualified Event during the year.

Special Enrollment Rights

The Health Insurance Portability and Accountability Act ("HIPAA") provides you with Special Enrollment Rights in addition to the open-enrollment period even if you previously declined medical coverage.

You may enroll yourself and any other eligible dependent(s) if:

- You had originally declined Ameriprise Financial, Inc. medical coverage because of other medical coverage, but that coverage has now been lost due to:
    - Loss of eligibility under a non-COBRA plan, including an individual insurance policy

    - Termination of your spouse's/domestic partner's/domestic partner's child(ren) or dependent's coverage through his or her employer due to either loss of eligibility, exhaustion of coverage, because the employer stopped making contributions toward non-COBRA plan premiums, or because of reaching the medical plan's lifetime limit on benefits coverage
    - Exhaustion of COBRA coverage (termination due to failure to make payment does not constitute a "loss" of coverage.)
- You marry, or your spouse/domestic partner gives birth or adopts a child, or a child is placed with you for adoption.
- You or your dependent(s) lose coverage under Medicaid or Children's Health Insurance Program ("CHIP") due to a loss of eligibility (other than non-payment).
- You or your dependent(s) become eligible for government premium assistance under Medicaid or CHIP.

Special Enrollment Rights entitles you for "like" coverage with Ameriprise Financial, Inc. For example, if you lose other medical coverage, you may enroll in medical coverage with Ameriprise. You cannot enroll, however, in dental and/or vision or in the spending accounts due to HIPAA Special Enrollment Rights (see "Qualified Events" for other possible opportunities to enroll in these plans). Special Enrollment Rights do not apply to the vision, dental or reimbursement account plans.

Qualified Events

Changes to your benefit elections may only be made if you experience a Qualified Event. A Qualified Event is an event listed in the following chart that results in the gain or loss of eligibility for health insurance coverage by you, your spouse/domestic partner or your dependent(s) as defined by the Internal Revenue Code. If you have a Qualified Event, **your change in coverage must be consistent with that event.** For example, you cannot cancel coverage for an individual who has become eligible for coverage under another plan unless that person actually becomes covered under the other plan.

The following chart outlines Qualified Events under the Ameriprise Financial, Inc. Medical, Dental, Vision, Dependent Care and Health Care Reimbursement Account Plans.

Event	Benefit			
	Medical, Dental, Vision & Legal Assistance Plan	**Life Insurance** (Remember to keep your beneficiary current)	**Health Care Reimbursement Account**	**Dependent Care Reimbursement Account**
Marriage	• Enroll in coverage • Drop coverage • Add or drop dependents Changing plan options, such as changing from the Premium PPO to the Basic PPO is allowed	• Add coverage of new dependent • Enroll or increase your own coverage with Statement of Health approval	• Enroll or increase contributions • Drop or decrease contributions	• Enroll or increase contributions • Drop or decrease contributions if new spouse has dependent care reimbursement account • Drop if new spouse makes you ineligible (doesn't work outside the home)

Event	Benefit			
	Medical, Dental, Vision & Legal Assistance Plan	**Life Insurance** (Remember to keep your beneficiary current)	**Health Care Reimbursement Account**	**Dependent Care Reimbursement Account**
Divorce, legal separation, annulment, or death of spouse/domestic partner	• Drop coverage • Change coverage level • Add coverage if lost under spouse/domestic partner plan due to event Changing plan options, such as changing from the Premium PPO to the Basic PPO is allowed	• Drop coverage	• Enroll or increase contributions • Drop or decrease contributions	• Enroll or increase contributions • Drop or decrease contributions
Birth or adoption	• Enroll in coverage • Drop coverage • Change coverage level Changing plan options, such as changing from the Premium PPO to the Basic PPO is allowed	• Add coverage of new dependent • Enroll or increase your own coverage with Statement of Health approval	• Enroll or increase contributions for newly eligible dependent • Drop or decrease coverage	• Enroll or increase contributions to account for newly eligible dependent expenses
Dependent child loses eligibility due to attainment of age 26	• Coverage must be dropped for the dependent plans. Changing plan options, such as changing from the Premium PPO to the Basic PPO is allowed	• Coverage must be dropped for ineligible dependent	• You may decrease or drop contributions to account for lost dependent.	• Drop or decrease contributions

Event	Benefit			
	Medical, Dental, Vision & Legal Assistance Plan	**Life Insurance** (Remember to keep your beneficiary current)	**Health Care Reimbursement Account**	**Dependent Care Reimbursement Account**
You or your spouse/domestic partner or eligible dependent gain or lose coverage through an employment status change (including a commencement or return from an unpaid FMLA leave of absence), during their employer's open-enrollment period or gain Medicare coverage	• You may enroll or drop the individual that has gained or lost coverage through their own employer. Changing plan options, such as changing from the Premium PPO to the Basic PPO is allowed	• You may enroll or increase coverage with Statement of Health approval.	• You may enroll, increase, drop or decrease contributions to account for individual being added or dropped from coverage.	• Enroll or increase contributions • Drop or decrease contributions
Changes to your day care services or needs: • Provider changes hours, cost, location or available services • You change providers to meet changes in your needs	N/A	N/A	N/A	• Enroll or increase contributions • Drop or decrease contributions

All changes **must** be consistent with the Qualified Event. For example, the birth of a baby would be a Qualified Event. The baby is a newly eligible dependent, and this allows you to enroll or increase coverage according to the chart above.

When coverage ends

Participation in the Health and Wellness Benefit Plans ends on the day you terminate employment.

Any cost for plan coverage in force but unpaid at the time of termination or commencement of a long term unpaid leave may be withheld from your final paycheck, except amounts that would have been used to purchase vacation.

In some circumstances, coverage can be continued under the Medical, Dental, Vision Care, Life Insurance and Health Care Reimbursement Account. For information on continuing health care coverage, please see the section "*Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA)"* in this SPD for more details.

You may be eligible for an extension of coverage while you are receiving payments under the Severance Pay Plan depending on your years of service with the company. See the Severance Pay Plan SPD for more information.

The date coverage ends

Coverage under any of the benefit plans will end on the earliest of the following dates:

- The day of the month you (or your dependents) are no longer eligible
- The date the plan is terminated (in the event a portion of a plan is terminated, the corresponding portion of your coverage (or the coverage of your dependents) will end on the termination date)
- The end of the period for which you last made a contribution for coverage, if you fail to make a contribution when it is due
- The specific day you (or your dependents) experience a qualified event, provided the HR Service Center receives your request for voluntary cancellation of coverage within 60 days after a qualified event
- The specific date of the month on which you terminate employment.
- The last day of the calendar year, in the event you did not elect coverage (for yourself and/or your dependents) for the following year during the open-enrollment period
- The date you (or your dependents) cease to be a member of an eligible class (for example, regular part-time employee, spouse/domestic partner, or COBRA participant)

When coverage ends for residents of Hawaii

If you are employed in Hawaii and are unable to work due to hospitalization or illness, coverage will continue for the longer of:

- Three months following the month in which you became disabled or
- The period of time salary continuation is payable

Expenses incurred after coverage ends

You are responsible for any benefit expenses that are incurred after your coverage has terminated. However, under certain circumstances, you may be eligible to receive a refund of contributions you paid. In no event will the refund exceed two months' worth of contributions. Keep in mind that if you do not follow the specific procedures for notifying the company of a change in eligibility (either for yourself or a previously eligible dependent) as well as follow any instructions given at the time of notification and coverage is terminated retroactively to the date of the eligibility change, you will be responsible for any expenses incurred on or after the date of the eligibility change

Also, your failure to notify the HR Service Center within 60 days of a qualified status change that makes your dependent ineligible for coverage will jeopardize your dependent's right to continuation of coverage under COBRA, if applicable.

Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA")

As part of COBRA, you and/or your eligible dependents who would otherwise lose health coverage under the Medical Plan (including the Employee Assistance Program and the Health Services Clinic), the Dental Plan, Health Care Reimbursement Account and/or the Vision Care Plan as a result of the circumstances described in the COBRA Coverage Chart below, may (at your own expense) elect to continue coverage. If you or your dependents are not covered under a particular plan, you are not eligible for continuation coverage. However, children born or adopted while you are receiving continuation coverage are also eligible to be covered for that benefit(s), at your own expense, provided proper notice of the birth or adoption is provided to HealthEquity, the COBRA claims administrator, within 60 days of the event.

Coverage under the Employee Assistance Program portion of the Medical Plan continues automatically at no cost to you for the maximum period shown in the COBRA Coverage Chart.

You and your enrolled dependents will become eligible for COBRA coverage when coverage would be lost due to the occurrence of any of the following qualified events. COBRA coverage may continue up to the maximum period described.

COBRA coverage chart

Qualifying Event	Maximum coverage period*
Reduced work hours < 20 hours per week	18 months
Employment termination or retirement (except for gross misconduct)	18 months
Employee's death	36 months
Divorce, legal separation or annulment	36 months
Employee's enrollment in Medicare prior to termination	36 months
Dependent child's eligibility ends (for example, by exceeding plan's age limit)	36 months

*If there are multiple events, the coverage period cannot exceed 36 months. The maximum coverage period for the Health Care Reimbursement Account is the end of the calendar year in which the qualifying event occurs.

Disability extension notice requirements

If you and/or your dependents are eligible for 18 months of COBRA coverage, coverage may be extended for an additional 11 months, if you or one of your dependents are disabled and eligible for Social Security disability benefits at the time of the qualifying event or during the first 60 days after the qualifying event.

You or your dependent must provide HealthEquity with notice of the disabled individual's eligibility for Social Security Disability Insurance ("SSDI") within 60 days of your or their enrollment in COBRA continuation if the disabled individual was eligible for SSDI at the time of the qualifying event. If you or your dependent are awarded SSDI while in your initial 18 months of COBRA continuation, you or your dependent must notify HealthEquity before the first 18 months of coverage ends, and within 60 days of the determination by Social Security. Failure to provide HealthEquity with a copy of your disability determination within the required timeframe may result in a denial of your extension.

Send Notice of SSDI to HealthEquity P.O. Box 14055, Lexington, KY 40512, 1.877.502.6272.

If during continued coverage, the Social Security Administration determines that you or your dependent are no longer disabled, you and your dependent must notify HealthEquity of that determination within 30 days.

When to elect COBRA coverage

You will have 60 days from the date your coverage would otherwise end or the date on which HealthEquity notifies you of your continuation option, whichever is later, to elect COBRA continuation coverage. Each qualified beneficiary has a separate right to elect continuation coverage. For example, your spouse/domestic partner may elect continuation coverage even if you do not. If the qualified beneficiary does not return the election form within 60 days, COBRA rights terminate and the individual will not be entitled to extend coverage. A qualified beneficiary who, during the election period, voluntarily waives COBRA continuation coverage can revoke the waiver at any time before the end of the election period. If you elect COBRA continuation coverage, you will then have 45 days from the date of your election to make your first payment, which must include all retroactive premiums due. (See section titled "*Payment for coverage and termination of coverage"* for more information.)

Please note that the Coronavirus Aid, Relief and Economic Security Act of 2020 (the "CARES" Act) may affect these deadlines for 2020 and 2021.

Notification

Ameriprise Financial is responsible for notifying you (or your dependents) of your right to purchase COBRA coverage following a change in your employment status with the company, your death, or your entitlement to Medicare.

Upon a divorce, legal separation, annulment, or when a dependent child's eligibility ends, you or your dependent are required to inform the HR Service Center of the event. Call the HR Service Center at 1.877.267.4748 within 60 days after the date of the event and a Benefit Specialist will drop your dependent.

You or your eligible dependents will in turn be provided with a notification of your rights and an enrollment request form along with the expected monthly cost for continuing group health plan coverage. Notice to your spouse/domestic partner is deemed to be notice to all other qualified beneficiaries residing with such spouse/domestic partner at the time notification is made. If you or your dependent are already on COBRA when a second qualifying event occurs (for example, your employment terminates, you elect COBRA for yourself and your dependent child and while you are on COBRA, your dependent child ceases to be eligible as a dependent child), you must contact HealthEquity at 1.877.502.6272 within 60 days after the second event occurs.

Your coverage following a qualified status change

Generally, the health care plan elections in place at the time of the Qualified Event determine the coverage you and your dependents will have during the remainder of the plan year (or the end of continuation coverage, if earlier). Your election, or that of your spouse/domestic partner, is deemed to include an election of continuation coverage on behalf of all other qualified beneficiaries who would otherwise lose coverage by reason of a Qualified Event, unless otherwise specified on the enrollment request form. During the open enrollment period, you and/or your dependents may change coverage in the same manner as active employees.

Continuing coverage under the Health Care Reimbursement Account

The Health Care Reimbursement Account is available to you under continuation coverage in accordance with COBRA. However, because this plan is offered to active employees on a before-tax basis through payroll

deductions, the income tax advantage usually gained by participating in this plan is not available to terminated employees and/or their dependents that choose continuation coverage. Individuals who are no longer on the payroll and who want to continue contributing under this plan must do so on an after-tax basis. Continuation coverage is available only through the end of the calendar year in which the Qualify Event occurs.

Payment for coverage

The cost of COBRA coverage is 102% of the full group rate. In case of extended coverage due to disability, the cost of coverage for months 19 through 29 is 150% of the full group rate, including the company contribution. You must pay your premiums for any period of COBRA coverage.

COBRA requires you and your dependents to pay promptly for this coverage. You will be notified by the company or HealthEquity, of the amount of such payments (which include the employee and employer cost plus the 2% or 50% administrative charge permitted by law) and will be billed monthly. Payment must be received within 31 days of the due date. Failure to make payment within 31 days of the due date will result in termination of this coverage as of such due date; it cannot be reinstated. The initial COBRA premium payment is due not later than 45 days after the date you or your dependents elected COBRA coverage and no grace period applies to the initial payment. If the initial payment is not made within 45 days after COBRA is elected, the COBRA election is not effective. Payment is considered made as of the postmark date.

Termination of coverage

Continuation coverage will terminate prior to the end of the maximum continuation coverage period if:

- The qualified beneficiary continuing coverage ceases to make the necessary payments on a timely basis
- After COBRA is elected, a qualified beneficiary continuing coverage first becomes covered under another group health plan, and that plan does not contain any exclusion or limitation with respect to any pre-existing condition affecting that qualified beneficiary
- After COBRA is elected, a qualified beneficiary continuing coverage first becomes entitled to Medicare
- In the case of extension due to Social Security disability, a determination is made that the individual is no longer disabled (after the first 18 months)
- Ameriprise Financial no longer maintains the Medical, Dental, Vision, Health Care Reimbursement Account, Employee Assistance Program or Health Services Clinic.

Severance benefits

If you receive severance benefits in installments under the Severance Pay Plan, your coverage will continue (with the exception of long term disability insurance and purchased vacation), and your benefits costs will be deducted from your bi-weekly serial severance payments. When your bi-weekly serial severance payments cease, your coverage ends. However, you may be eligible for COBRA at that time and at your own expense.

If you receive a lump-sum severance payment, your employment terminates immediately, and you may elect to continue certain coverage under COBRA at your own expense.

Coverage options other than 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, Medicaid, or other group health plan coverage options (such as a spouse's/domestic partner'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.

Leave of absence and time off provisions

Company policies include a variety of leaves of absence and time off provisions to provide employees with the time and flexibility to address personal needs. For example, Family and Medical Leave Act ("FMLA") leaves are available to employees who need to take time off for their own serious health condition or that of a close family member, or to care for their newborn or newly adopted child. Following are the types of leaves and time off provisions that are available, depending on your personal situation:

- Unpaid Medical Leave
- Personal Leave
- Family and Medical Leave (FMLA)
- State Paid Family Leave
- New Hire Medical Leave
- Salary Continuation
- Workers Compensation Leave
- Military Leave
- Jury Duty & Witness Time Off
- Bereavement Leave
- Maternity Leave
- Parental Leave

Further information about leaves of absence, FMLA and time off provisions may be accessed through the Ameriprise intranet *Inside* or by calling Employee Relations at 1.877.267.4748, option 2.

If any state laws are more beneficial to employees than the company policies regarding leaves of absence and/or time off, the state laws will supersede the company policies.

Medical coverage if you are disabled

If you become totally disabled during active employment, your medical plan coverage will continue, if enrolled, during the period of time you are receiving salary continuation benefits, as well as during any unpaid medical leave.

Employees who are totally disabled are eligible for one month of unpaid medical leave for each completed year of service (up to a maximum of 24 months), following the end of salary continuation. During your unpaid medical leave, your medical coverage (including prescription drug coverage) continues as well as coverage for the other plans you are enrolled in, provided you pay the employee contribution amounts for your coverage.

Coordination of benefits

The Medical Plan is designed to help you meet the covered expenses that you and your covered dependents actually incur. Members of a family may be covered under more than one group medical plan (for example, if a husband and wife both are employed and have medical coverage through their employers). This kind of duplication can frequently result in two plans covering the same healthcare expense and can unnecessarily raise the cost of benefits coverage. You cannot be enrolled in more than one company-sponsored medical plan option at a time.

To help guard against such duplication and thereby ensure that you obtain maximum benefits at a minimum cost, the Medical Plan (like most plans) has a Coordination of Benefits ("COB") provision. The important point to remember about coordination of benefits is that its purpose is to ensure that you receive all of the benefits to which you are entitled under all group plans. This helps keep down the cost of medical coverage by eliminating duplicate payments.

Whenever you are covered under another group medical plan in addition to the company Medical Plan, the company Medical Plan will pay only up to the limits specified by the option you select. Your reimbursement from both group plans will be limited to the reimbursement you would have received from the company Medical Plan alone.

Coordination with Medicaid

Eligibility for benefits received from Medicaid will not affect the eligibility for benefits received from the Medical Plan. The Medical Plan will pay benefits in accordance with any assignment of benefits required by a state Medicaid agency. In addition, the Medical Plan will recognize and honor the subrogation rights of a state Medicaid agency if the agency has paid benefits that the Medical Plan is responsible for paying. For prescription drug benefits, see the Prescription Drug SPD.

Determining the primary plan

Here are guidelines for identifying the primary plan:

- The plan that covers a person as an employee is primary over a plan that covers a person as a dependent.
- A plan that covers an individual who is actively at work pays benefits before a plan that covers the individual as a retired or laid-off participant. The same rule applies for dependents of individuals who are actively at work and dependents of those who are retired or laid-off. However, the rule will not apply unless the other plan has the same rule.
- A plan that has no COB provision is primary over a plan that does have a COB provision.
- If your dependents also are covered as dependents under another plan, the company Medical Plan is primary for them if the month and day of your birthday falls earlier in the year than the month and day of the birthday of the person whose dependents are in the other plan. If the month and day of your birthday falls later in the year, the other plan is primary. If the birthdays are the same, the company Medical Plan is primary if it has covered you for a longer period of time. This is known as the birthday rule. If the other plan does not use the birthday rule, the rules of that plan determine which plan is primary.
- If there is a court decree that states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the birthday rule (as described above) will determine which parent's plan is primary.
- If a court decree gives financial responsibility for the child's medical, dental or other healthcare expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
- If you are divorced or separated, the following COB rules will apply:
    - The plan of the parent with custody pays benefits first.
    - The plan of the step-parent married to the parent with custody will pay benefits next.
    - The plan of the parent without custody will pay benefits next.

If a Qualified Medical Child Support Order (QMCSO) specifies that one parent is responsible for a child's healthcare expenses, that parent's plan pays first.

If none of the rules above apply, the plan that covered the person for the longest period of time will be primary. If you or any members of your family are covered under more than one group plan, including automobile no-fault insurance or Medicare, you must check with the claims administrator to determine how the COB provision applies.

Administration

This section contains information on the administration and funding of the Ameriprise Financial Health and Wellness Plans, collectively called the "Plans", as listed in *Appendix A: Plan facts*, and your rights as a plan participant under the Employee Retirement Income Security Act of 1974 (“ERISA”).

For further information about the administration of the Plans or for further information about the Plans in general, please contact Ameriprise Financial, Inc., HR Service Center, 9897 Ameriprise Financial Center, Minneapolis, MN 55474. Or call 1.877.267.4748

Plan Administrator

The Plan Administrator is the Employee Benefits Administration Committee (“EBAC”) of Ameriprise Financial, Inc. The address is Ameriprise Financial, Inc., Employee Benefits Administration Committee, 360 Ameriprise Financial Center, Minneapolis, MN 55474.

Named Fiduciaries

The EBAC is a “named fiduciary” under the Plans. The EBAC shall consist at all times of individuals appointed by the appointing fiduciaries. The appointing fiduciaries (acting jointly and not severally) may from time to time appoint new and/or remove EBAC members. An EBAC member who ceases to be an employee will cease to be an EBAC member unless otherwise expressly agreed. For purposes of this section, the “appointing fiduciaries” shall be the company’s Senior Vice President – Benefits & HR Operations and the Senior Vice President – Strategy. The EBAC shall discharge the duties and responsibilities and shall have the authority specified in the Plans. EBAC members shall serve without compensation for such service but shall be entitled to be reimbursed for any amounts reasonably and necessarily expended by them in the performance of their duties hereunder.

EBAC Procedures

The EBAC shall (a) hold such meetings as it determines to be necessary or appropriate for the proper performance of its duties hereunder; (b) elect from its own number a Chairperson; (c) elect or appoint a Secretary who may, but need not be, a member of the EBAC; and (d) keep such records of its meetings and actions taken as it determines to be necessary or appropriate in the circumstances.

The EBAC shall act by majority vote of a quorum of its members either at a meeting or in writing (including electronically); provided, however, that the EBAC may by a vote so taken constitute a subcommittee consisting of one or more of its members (including a subcommittee of the whole), or may appoint one or more delegates, with such duties, responsibilities and authority and operating under such rules as the EBAC may specify; provided, however, such delegate or subcommittee may only further delegate its duties, responsibilities and authority with the express consent of the EBAC. When such subcommittee or delegate(s) are acting within the scope of the duties, responsibilities and powers so specified, references to the EBAC herein shall include a reference to such subcommittee or delegate(s). In all events, EBAC members shall be disqualified from acting upon any matter affecting only them.

By appropriate written action the EBAC may authorize one or more of its members, its Secretary or any Administrative Delegate to execute documents on its behalf, until such authorization has been revoked by the EBAC in writing.

The EBAC shall have the authority to employ or retain such accounting, legal, medical and clerical services as it may determine to be necessary or appropriate for the proper discharge of its functions.

Duties and Powers of EBAC

(a) In General. Without limiting the scope of such other duties, responsibilities and authority as may elsewhere in the Plans be specified as belonging to it, the EBAC shall have the power, the duty, and the complete and exclusive discretion to: administer the Plans and to establish such rules and regulations in connection therewith as it determines to be necessary or appropriate in the circumstances; conclusively make all determinations necessary for the administration of the Plans, including without limitation determinations as to eligibility to participate and eligibility for benefits; construe, interpret, and supplement the Plans whenever necessary to carry out its intent and purpose and to facilitate the Plans' administration; decide any claims arising out of or related to a denial of Plan benefits or the administration or operation of the Plans or the investment of Plan assets, including but not limited to claims for benefits, participation rights and breach of fiduciary duty under ERISA Section 502; provide for the bonding of all fiduciaries, Plan officials and other similar persons at least to the extent required by ERISA; and prepare, file with the appropriate governmental agency, furnish or make available to appropriate Participants and beneficiaries, the various statements, reports, descriptions, registrations and other documents all as required by ERISA, or cause such filings to be prepared and made, and in all cases involving Plan administration, to have the discretion to determine when an electronic document shall be considered equivalent to a written document. In addition, the EBAC shall have the power, the duty, and the complete and exclusive discretion to appoint one or more independent fiduciaries or other independent service providers to provide such services and perform such functions in furtherance of the EBAC's duties and responsibilities hereunder as the EBAC in its discretion determines. Any such appointed fiduciary or other service provider shall have such powers and authority (otherwise exercisable by the EBAC), other than the authority to appoint fiduciaries, as the EBAC determines.

In addition, the EBAC shall have the discretionary authority to interpret and construe the terms certain American Express Health and Wellness Plans listed that relate to benefits payable (or claimed to be payable) to an Ameriprise employee who was covered under one or more of these plans (including the right to supply any omission, construe any ambiguous or uncertain terms, and reconcile any inconsistencies), and the discretionary authority to determine and resolve any and all questions related thereto.

(b) Administrative Delegates. Persons (other than subcommittees of the EBAC) to whom the EBAC delegates duties, responsibilities and authority pursuant to the section EBAC Procedures are referred to herein as "Administrative Delegates." Each Administrative Delegate shall have the authority to take such administrative actions and make such determinations, in each case within the scope of his or her delegation, as are within the authority of the EBAC. Each Administrative Delegate will perform his or her duties within the framework of the policies, interpretations, rules, practices, and procedures made by the EBAC. An Administrative Delegate's functions may include, by way of illustration and not limitation, the following: application of rules determining eligibility for participation or benefits; calculation of participation service and compensation used for determining contributions or benefits; preparation of employee communications material; maintenance of an individual's service and employment records; preparation of reports required by government agencies; calculation of contributions or benefits; orientation of new participants and advising participants of their rights and options under the Plans; collection of contributions and application of contributions as provided in the Plans; preparation of reports concerning participants, alternate payees and beneficiaries' benefits; processing of claims, distribution requests, and investment elections; and making recommendations to others for decisions with respect to administration of the Plans.

Freedom from Liability

(a) Members of the EBAC and any delegate, may rely upon all certificates and reports made by any plan

consultant selected or approved by the company; and upon all opinions given by legal counsel retained by the company or the EBAC.

(b) Subject to the fiduciary requirements of ERISA, members of the EBAC, and any delegate, shall be fully protected in respect of any action taken or not taken in good faith and in reliance upon advice and recommendation of any plan consultant or legal counsel. Furthermore, subject to the right of review granted in the *Filing and appealing a benefits claim* section in this SPD, in the case of matters subject thereto, all action taken or not taken by the foregoing bodies or individuals shall be conclusive upon all parties having any interest under the Plans to the maximum extent permitted by law.

(c) Should circumstances beyond its control render the EBAC unable to perform or incapable of performing any action within the time constraints or in the manner set forth herein or pursuant to rules established hereunder, the EBAC shall be free from any liability arising therefrom.

(d) To the extent permitted by law, the affiliated employers shall indemnify the members of the EBAC, and others to whom fiduciary duties have been delegated who are either employees, officers or directors of any affiliated employer against any and all claims, losses, damages, expenses and liabilities arising from their responsibilities in connection with the Plans which are not covered by insurance (without recourse) paid for by the affiliated employers, unless they are determined to be due to gross negligence or intentional misconduct.

Correction of Errors

In the event of a mathematical or accounting error made, or other similar mistake, the EBAC shall have power in its discretion to cause such equitable adjustments to be made to correct for such errors as it considers appropriate in the circumstances. In addition, the EBAC may correct obvious and unambiguous typographical errors and/or cross references that merely correct a reference, but that do not change the original intended meaning of the provisions. All adjustments and corrections made pursuant to this section shall be final and binding on all persons. Without limitation of the foregoing, if the EBAC determines in its sole discretion that a Plan made an incorrect payment of benefits, and that a correction is necessary or desirable under the law, then (i) if the Plan makes an overpayment of the amount of any benefits due any payee under the Plan, the Plan may recover the amounts either by requiring the payee to return the excess to the Plan, by reducing any future Plan payments to the payee, or by any other method that the EBAC deems reasonable, and (ii) if the Plan makes a late payment or an underpayment of the amount of any benefits due any payee under the Plan, correct payment will be made as soon as reasonably possible after the late payment or underpayment is discovered. The Plan's rights to recover an overpayment extend to any subsequent recipient of all or any part of the overpayment (to the extent of the overpayment received by such person), including any individual, and the Plan has an equitable lien for the full amount of any overpayment.

Further, from time to time, claims or issues may arise that involve a Plan, including, among others, claims and issues raised by Participants, those addressed under any of the Internal Revenue Service's Employee Plans Compliance Resolution System programs, United States Department of Labor Voluntary Fiduciary Correction Program, or similar programs. The resolution, settlement, or adjudication of these claims or issues may result in an action that is not expressly permitted under some other section of a Plan document. Such a procedure, agreement, or order will be respected to the extent that, as determined in the sole discretion of the EBAC, it does not result in disqualification of the Plan or violate (or cause the Plan to violate) any applicable statute, government regulation, or ruling.

Payment of Plan Expenses

The reasonable expenses of administering the Plans including, but not limited to attorney fees, actuarial fees and expenses incurred by persons or entities to whom fiduciary duties have been delegated, shall be paid from the assets of the Plan(s) unless paid by an affiliated employer.

The EBAC is responsible for ensuring that only expenses that are properly chargeable to a Plan under ERISA are taken into account in determining the cost of Plan benefits. The basic requirement to be considered a proper Plan expense is that the expense must be for the purpose of providing benefits to participants and beneficiaries (for example, a premium paid to the insurance carrier that insures the benefit or the benefit claims cost paid under a self-insured plan) or must be a reasonable expense for the administration of the Plan (for example, the administrative service fee paid to a third party claims administrator for a self-insured Plan).

Burden of Proof

Notwithstanding anything herein to the contrary, to the extent a person asserts entitlement to benefits based upon facts not contained in a Plan's records, such individual shall be required to provide satisfactory affirmative evidence of such facts. For avoidance of doubt, if an individual claims entitlement to benefits based upon compensation or years of service that are not reflected in the Plan's records, such individual must provide satisfactory affirmative evidence of such compensation or years of service. The EBAC (or its Administrative Delegate) shall have the sole and exclusive discretion to determine whether the above-referenced affirmative evidence is satisfactory.

Plan Sponsor

Ameriprise Financial, Inc. is the Plan Sponsor. The address is Ameriprise Financial, Inc., Corporate Benefits, 360 Ameriprise Financial Center, Minneapolis, MN 55474.

Employer identification number

The employer identification number assigned to Ameriprise Financial, Inc. by the IRS is: 13-3180631.

Claiming benefits

As a participant in any of the Plans listed in *Appendix A: Plan facts,* you may have an inquiry or claim regarding administrative issues or the denial of benefits to which you believe you are entitled. An administrative claim or inquiry involves issues such as:

- Enrollment
- Eligibility

A benefit claim involves issues such as:

- Payment of a claim
- Reimbursement for services
- Determining whether services are covered or medically necessary

Administrative inquiries/claims

The HR Service Center serves as the reviewer of initial inquiries and first level appeals in connection with administrative claims for any of the Plans listed in *Appendix A: Plan facts.* You may contact the HR Service Center at 1.877.267 4748 or send written correspondence to Ameriprise Financial, Inc., HR Service Center, 9897 Ameriprise Financial Center, Minneapolis, MN 55474.

An example of an administrative inquiry/claim is a request for an enrollment exception. This occurs when an employee misses the enrollment period when they are first eligible, during open enrollment or within 60 days of a Qualified Event. If employees do not enroll during this period, they must wait until the next open-enrollment period or until they experience another Qualified Event or Special Enrollment Right in order to have Plan coverage.

If employees believe they have experienced extraordinary circumstances that caused them to miss the applicable enrollment period, they may contact the HR Service Center to review their claim. The request for a

review must be made within 120 days of the event that would have allowed enrollment. Any requests received after 120 days will not be reviewed.

If an employee is not satisfied with the response, they receive from the HR Service Center, they may submit a final written appeal to the Plan Administrator (EBAC) within 60 days of their receipt of denial. The EBAC serves as the Claims Fiduciary for administrative claims and its decisions are final and binding.

Any claims relating to the Plans described in this Summary Plan Description ("SPD") that are governed by ERISA, including any claims under state or local law that are subject to preemption under ERISA, are subject to the claims procedures as set out in this section of the Administration & Participation SPD and, if not satisfactorily resolved, may be brought in a court of competent jurisdiction. Any claim relating to such benefits that is not subject to preemption under ERISA is also subject to the claims procedures set out in this section of the SPD and, if not satisfactorily resolved, must be resolved through arbitration conducted by the American Arbitration Association, as governed by the company's arbitration policy, if any.

Filing and appealing a benefits claim

The Claims Administrator as listed in *Appendix A: Plan facts* serves as the reviewer of initial claim submissions and first- and second-level appeals in connection with benefit claims for any of the company's Health and Wellness Plans. If you have a benefits inquiry or claim, you may call or write the appropriate Claims Administrator. If you are filing a benefits claim in connection with medical necessity under the Delta Dental Plan option, the claims process as indicated below does not apply. These claims are governed in accordance with New York state law grievance procedures. Please contact the HR Service Center for a copy of these procedures. Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under a group health benefit plan. The claims procedures described in this SPD are intended to comply with those regulations by providing reasonable procedures governing filing of claims, notification of benefit decisions and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under the Plan for eligible services/charges.

Notification of benefit determination

The Claims Administrator must notify you of its initial decision within a specified number of days after receipt of the claim as indicated in *Appendix B: Timeframes for claim determinations and first-level appeals*. The Claims Administrator may request an extension due to matters beyond its control, as long as you are notified within the initial review period. If an extension is needed because additional information is required, the notice to you must specify what information is needed and the number of days you have to provide this information. In this case, the running of the time period for the Claims Administrator's making the determination is tolled (temporarily stopped) from the date on which the notice is sent to you until the date you respond to the notice.

If the Claims Administrator denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because the Claims Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. For health care and long term disability claims, if an internal rule, protocol or guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appeal of adverse benefit determination

If the Claims Administrator denies your claim, you may appeal the decision. Upon your written request, the Claims Administrator will provide you, free of charge, with copies of documents, records and other information relevant to your claim. You must submit your appeal to the Claims Administrator at the address indicated in *Appendix A: Plan facts* within the number of days specified in *Appendix B: Timeframes for claim determinations and first-level appeals*. Appeals must be in writing (except for appeals involving urgent health claims, which may be oral) and must include the following information:

- Name of employee
- Subscriber number (found on your ID card)
- Name of the plan
- Reference to the initial decision
- Explanation of why you are appealing the initial determination

As part of your appeal, you may submit written comments, documents, records or other information relating to your claim. Except in the case of urgent health claims, the claims process does not allow oral presentations or specific questions of the Claims Administrator.

After the Claims Administrator receives your written request appealing the initial determination, the Claims Administrator will conduct a full and fair review of your claim. For health care and long term disability claims, deference will not be given to the initial denial, and the Claims Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

The Claims Administrator will notify you in writing of its final decision within a period of time as specified in *Appendix B: Timeframes for claim determinations and first-level appeals*, upon the Claims Administrator's receipt of your written request for review, except that under special circumstances the Claims Administrator may have an extension to provide written notification of its final decision. If such an extension is required, the Claims Administrator will notify you prior to the expiration of the initial period, state the reason(s) why such an extension is needed and state when it will make its determination. If an extension is needed because you must submit additional information necessary to decide your claim, the notice to you must specify what information is needed and the number of days you have to provide the information. In this case, the running of the time period for the Claims Administrator's making the determination is tolled (temporarily stopped) from the date on which the notice is sent to you until the date you respond to the notice.

You will have the number of days as specified in the *Appendix B: Timeframes for claim determinations and first-level appeals* to provide the requested information from the date you receive the notice from the Claims Administrator.

If the Claims Administrator denies the claim on appeal, the Claims Administrator will send you a written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. For health care and long term disability claims, if an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision

will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Second level of appeal of adverse benefit determinations

If you receive a denial of your health care claim appeal from the Claims Administrator, you may file a second-level appeal of that denial within the number of days specified for first level appeals in *Appendix B: Timeframes for claim determinations and first-level appeals* to the Claims Administrator. You are entitled to a full and fair review of your claim appeal as described in the previous section titled *Appeal of adverse benefit determination*. Once you have filed and received a determination on one or two levels of appeals as appropriate for a health care claim (including prescription drug, dental or vision), a long term disability claim or life insurance claim, you have the right to bring a civil action under ERISA 502(a) to pursue your claim. If your claim is in connection with any other plans, you will be required to file a next level appeal with the EBAC in order to exhaust your administrative remedies. If you are not satisfied with the EBAC's decision, you then have the right to file suit under ERISA 502(a). If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration of the U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington D.C. 20210, telephone: 1.202.219.4377.

External Review

If your second-level appeal is denied, and you are not satisfied with the decision of your second-level appeal under the Medical Plan, including prescription drug coverage, you may have the right to obtain an independent external review. You have four months to file a request for an external review after receiving a notice of adverse benefit determination. Details about the process to initiate an external review as well as first- and second-level appeals are described in the Ameriprise Financial Medical Plan Summary Plan Description and Ameriprise Financial Prescription Drug Program Summary Plan Description.

Timeframes for claim determinations and first-level appeals

Generally, you will receive payment or denial of an application for benefits within certain timeframes from the date a claim is properly filed. When you file an appeal, specific timeframes also apply based on the type of claim, as outlined in *Appendix B: Timeframes for claim determinations and first-level appeals*. If payment of a claim or notice of a claim denial is not furnished within these timeframes, you should consider the claim to be denied and, if you so decide, proceed to the next stage of filing claims.

Claims fiduciary

Ameriprise Financial, Inc. has delegated to certain claims administrators the discretionary authority and fiduciary responsibility under ERISA to make claim determinations and to provide a full and fair review of appealed claims including determining any final appeals of claims. These claims administrators are known as claims fiduciaries as listed in *Appendix A: Plan facts*. Claims fiduciaries' duties include the discretionary authority and fiduciary responsibility under ERISA to determine:

- What constitutes a benefit and what constitutes a claim under the applicable Plan
- Utilization review that results in concurrent or prospective approval or denial of benefits
- What constitutes a reasonable and customary charge for benefits covered under the applicable Plan

Claims fiduciaries decisions are conclusive and binding on all parties and are not subject to further review.

As noted in *Appendix A: Plan facts*, EBAC also serves as the claims fiduciary for certain Health and Wellness Plans.

Other than their role as claims fiduciaries, any services provided by these claims fiduciaries will not affect the EBAC's acknowledged status as the Plan Administrator and accordingly, the EBAC will retain sole fiduciary duties and discretionary authority in connection with its role and duties as Plan Administrator other than the role of claims fiduciary where applicable.

Payment of claims

Insured Plans

Each insurance company is responsible for the payment of all benefits offered under the plan it insures. For each insured plan, program or option, the insurance company will have the sole authority, discretion and responsibility to interpret and apply the terms of the plan, program or option, including entitlement to benefits and the amount of benefit to be paid under the insurance contract, if any.

The liability of Ameriprise Financial, Inc. with respect to an insured plan is limited to the payment of premiums from its general assets. No covered employee, dependent or other person will have any claim or cause of action against Ameriprise Financial, Inc. as to the payment of benefits under any insurance policy or contract while the plan is in effect. Each covered person or other claimant entitled to the payment of benefits under an insured plan shall look solely to the applicable insurance policy or contract and not to Ameriprise Financial, Inc. for payment of such insured benefits. Fully insured plans include: Medical (BCBS HI), Dental (Cigna DHMO), Vision Care (EyeMed), Life Insurance and Long Term Disability (MetLife) and Legal Assistance (Hyatt Legal).

Self-insured Plans

Ameriprise Financial, Inc. is responsible for funding claims under the self-insured plans from its general assets. The claims administrators, also known as the claims fiduciaries, make all claims decisions, which are not subject to further review. Self-insured plans include: Medical (UnitedHealthcare) and Dental (Delta Dental). The claims fiduciaries for each self-insured plan are listed in *Appendix A: Plan facts*.

Uncashed checks

If you receive a claim check from one of the claims administrators for self-insured plans identified in *Appendix A: Plan facts*, the check must be cashed within 15 months from the date of issue for you to be entitled to payment. If extenuating circumstances prevented you from being able to cash the check within this time period, you may contact the HR Service Center to appeal this decision. If your appeal is denied, the assets will remain in the respective plan. Under no circumstances will you be entitled to payment if your check has not been cashed within two years from the date of issue.

Proof of claim

The Claims Administrator reserves the right to require verification of any alleged fact or assertion pertaining to any claim for benefits. For example, as part of the basis for determining health care benefits, the Claims Administrator may require submission of medical summaries, discharge reports, X-rays or other appropriate materials. To the extent that verification of benefits cannot be reasonably made, benefits may be less than otherwise would have been payable.

Assignment of benefits

Generally, benefits provided under these plans may not be assigned or transferred in any manner except as required by law. Life insurance can be assigned as a gift.

Subrogation and reimbursement

If you or your dependents receive benefits or covered services under one of the plans, options or programs sponsored by Ameriprise Financial, Inc., such plan shall be subrogated to the full extent of benefits paid under the plan or for the reasonable value of services covered under the plan. Subrogation means that the plan shall be reimbursed immediately from any amounts that you or your dependents and any attorneys receive – whether by suit, judgment, settlement, compromise or otherwise – from any person, entity, insurer or other plan that is or may be liable for:

- An accident, injury, sickness or condition that resulted in benefits being paid or covered services being provided under the plan
- Medical, dental or other expenses incurred by you or your dependents as a result of the accident, injury, sickness or condition

The plan or insurance company may file a lien against you, your dependents and others to secure its subrogation and reimbursement rights.

The plan or insurance company may also make a claim or file a lawsuit in your or your dependents' name to secure its subrogation and reimbursement rights.

Notwithstanding whether amounts received from such persons, entities, insurers or other plans are characterized as reimbursement for medical or dental expenses, disability, pain and suffering or for some other loss, these subrogation and reimbursement rights shall be a first priority claim against any such person, entity, insurer or other plan. The plan or insurance company will be entitled to be reimbursed for all amounts paid under the plan or for the reasonable value of all covered services provided under the plan before you, your dependents and/or any attorneys are entitled to keep any amounts received. If any balance remains after the plan or insurance company is fully reimbursed from any amounts received, you, your dependents and attorneys may retain those amounts.

Your and your dependents' duty to cooperate

You, your dependents and attorneys acting on your behalf must cooperate to secure enforcement of these subrogation and reimbursement rights. You, your dependents and attorneys must not take any action – including but not limited to settlement of any claim, which prejudices or may prejudice these subrogation and reimbursement rights. If requested, you, your dependents and your attorneys must complete and sign all forms and papers as are necessary to secure these subrogation and reimbursement rights. You and your dependents must inform the plan of potential or actual claims that you and your dependents have or may have against persons, entities, insurers or other plans. Identification of any and all persons, entities, insurers and other plans; date of accident, injury, sickness or condition; and any other necessary information required by the plan, its administrators and attorneys, shall be provided as soon as possible and, in all cases, before you or your dependents agree to any settlement or compromise. If the plan determines that you, your dependents or attorneys have failed to cooperate, you and your dependents will lose any right to continue coverage under the plan and the plan will be relieved of any obligation to pay for or cover previously provided medical, dental or other services or benefits. If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.

Notifying the company of a lawsuit

In the event a lawsuit is brought (or settlement negotiations are entered into with a third party) that relates to an accidental injury or illness for which a claim is or will be made under the plan, the company must be notified

immediately in writing. This written notice should be directed to Ameriprise Financial, Inc., Attn: Vice President – Benefits, 360 Ameriprise Financial Center, Minneapolis, MN 55474.

The plan reserves the right to determine when it is appropriate to withhold benefit payments and may do so whenever, in its judgment, there is any risk that the plan may not be able to successfully exercise its subrogation or lien rights.

Plan entitlements

The Plan(s) has the right to:

- Receive payment instead of you, your dependents, your survivors or your medical care providers. This is called the right of subrogation. It means that the plan has whatever rights you or your covered dependents have or had to recover expenses that the plan has paid or will pay.
- Be paid by you, your dependents, or your survivors out of amounts received through the person who caused the sickness or accidental injury. That right, called a lien, is automatically created upon payment by the responsible person, the person's carrier or other coverage.
- Withhold payment of your claims under the plan until the plan has received payment under its subrogation or lien rights.

The Plan(s) is entitled to full payment even if a settlement is reached for less than the total claim against the responsible person. It also is entitled to full payment if the settlement agreement does not specify those amounts that are paid related to medical expenses and those amounts that are paid related to other claims, or if the settlement agreement specifically allocates the settlement amount to other claims, such as pain and suffering, lost wages, and the like. The plan does not have a right to receive more than the amount you, your dependents and/or your survivors would otherwise receive.

Attorneys' fees

The Plan(s) will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any person, entity, insurer or other plan, unless, prior to incurring such fees or costs, the plan, in the exercise of its sole and complete discretion, has agreed in writing to pay all or some portion of fees or costs.

Changing or ending the Plans

The company reserves the right to change or end any of the Plans at any time without notice or consent. Eligible employees and their dependents have no vested rights to any plan benefits or policies listed in this SPD. The company also reserves the right to insure any benefits under the benefit plans or to establish any fund or trust for the payment of benefits under such benefit plans except as mandated by law. Most plans may be amended or terminated by action of the company's Chief Executive Officer, President or any Executive Vice President, or by action of the Board of Directors.

When the company changes or ends a Plan

The company's decision to change or end any of the Plans may be due to: changes in federal or state laws governing such employee wellness benefit plans; the requirements of the Internal Revenue Code of 1986, as amended or the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended; employee needs or company needs; the provisions of a contract or a policy involving a third party or an insurance company, or for any other reason. If the company makes a change or decides to end any of the Plans, it may or may not decide to set up different plans to provide similar benefits.

Receiving payment when a Plan ends

Generally, if one of the Plans ends, you will be entitled to receive payment for covered expenses (properly documented with a claim) incurred before the plan is ended but will not have any further rights under the plan. The amount and form of any final benefit you may receive will depend on any contract or insurance provisions affecting the plan and on company decisions. Because contributions under the plan will stop when the plan ends, the amount available to pay covered claims should not exceed the amount of such claims on the termination date. However, after all benefits have been paid and legal requirements have been met, any remaining plan money will remain with the company.

In the case of the Dependent Care Reimbursement Account and the Health Care Reimbursement Account, you will be eligible to receive payment (to the extent that amounts are credited to your Dependent Care Reimbursement Account and for your full annual amount in your Health Care Reimbursement Account) for covered expenses incurred before the plan ended, but will not have any further rights under the Plans. The amount and form of any final benefit you may receive will depend on amounts credited to plan accounts and on company decisions.

If you enrolled in the PPO and opened a Health Savings Account (HSA) through Optum Financial Bank, your HSA along with any funds held in that account remain yours even if the Medical Plan terminates.

Agent for service of legal process

Process can be served on the company or the Plan Administrator by directing service to Plan Administrator, c/o General Counsel, CT Corporation System, Inc., 405 Second Avenue South, Minneapolis, MN 55401.

Health Insurance Portability and Accountability Act

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and the HIPAA Security Rule, the following group health plans sponsored by the company have been amended to provide for the limited use and disclosure of protected health information and for the implementation of administrative, physical and technical safeguards to protect the confidentiality of electronic protected health information: Ameriprise Financial Medical Plan, Ameriprise Financial Dental Plan, Ameriprise Financial Vision Care Plan, Ameriprise Financial Employee Assistance Program and the Ameriprise Financial Health Care Reimbursement Account. You may obtain a hard copy of any of these group health plan amendments by contacting the HR Service Center at 1.877.267.4748.

ERISA Rights

The Health and Wellness Plans have been established by Ameriprise Financial, Inc. for the exclusive benefit of its eligible employees and eligible employees of its participating subsidiaries.

As a participant in one or more of the Plans, you are entitled to certain rights and protections under ERISA, which provides that you are entitled to certain rights and protections. You have the right to:

Receive information about your Plans and benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain copies of documents governing the administration of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

Continue group health plan coverage

- **Continue health care coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.**
- **Review this summary plan description and the documents governing the plan on the rules governing your Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), continuation of coverage rights.**

If you have creditable coverage from another plan, you may be able to get a reduction or elimination of exclusionary periods of coverage for preexisting conditions. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer: when you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases, if you request it before losing coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including Ameriprise Financial, Inc. or any other person, may terminate your employment or otherwise discriminate against you in any way in order to prevent you from obtaining a benefit to which you are entitled or from exercising your rights under ERISA.

Ameriprise Financial, Inc. is the fiduciary of the Plans, excluding the claims fiduciary for insured plans, programs or options and for all Medical Plan options, including the Prescription Drug Program, as specified in *Appendix A: Plan facts*. Each insurance company, medical plan option claims administrator, and prescription drug manager acts as the claims fiduciary, including determining entitlement to benefits and the amount of benefit to be paid under the plan, if any.

Enforce your rights

If your claim for a wellness 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 from the Plan Administrator or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court provided that you have exhausted your administrative rights under the plan. In addition, 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 plans' 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 the court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

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

Disclaimer

The SPDs on the Ameriprise Financial, Inc. intranet site *Inside* only contain certain highlights of some of the company's employee benefit plans. They do not supersede the actual provisions of the applicable plan documents, which in all cases are the final authority. The Plan Administrator has the full authority to exercise discretion in determining eligibility and in interpretation and administration of the Plans.

The Plans described herein may be amended or even terminated by the company at any time without prior notice to or consent by employees. The SPDs do not create a contract of employment between the company and any employee.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in: active duty for training; inactive duty training; full-time National Guard duty; the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an employee's behalf. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An employee may continue plan coverage under USERRA for up to the lesser of the:

- 24-month period beginning on the date of the employee's absence from work
- Day after the date on which the employee fails to apply for, or return to, a position of employment

Regardless of whether an employee continues health coverage, if the employee returns to a position of employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA

Appendix A: Plan facts

	Flexible Reimbursement Plan	Medical Plan and Prescription Drug Program	Dental Plan	Vision Care Plan
Formal Plan name	Ameriprise Financial Flexible Reimbursement Plan	Ameriprise Financial Medical Plan Ameriprise Financial Prescription Drug Program	Ameriprise Financial Dental Plan	Ameriprise Financial Vision Care Plan
Plan ID Number	512	501	501	502
Plan Year	January 1 – December 31	January 1 – December 31	January 1 – December 31	January 1 – December 31
Administration/ Funding	Claims Administration	Administrative Services Agreements (Separate agreements for Medical Plan and Prescription Drug Program.)	Administrative Services Agreement (Traditional Option and Routine Option) Insured (Dental Health Maintenance Organization Option)	Administrative Services Agreement
Insurer or Claims Administrator	Ameriprise Financial, Inc. Employee Benefits Administration Committee 360 Ameriprise Financial Center Minneapolis, MN 55474	Medical Plan – UnitedHealthcare Insurance Company UnitedHealthcare/ Medica Self-Insured - Appeals P.O. Box 30990 Salt Lake City, UT 84130-0990 Prescription Drug Program – Express Scripts P.O. Box 66587 St. Louis, MO 63166-6587	Delta Dental of New York* P.O. Box 2015 Mechanicsburg, PA 17055-6999 or CIGNA Dental Health, Inc. P.O. Box 189062 Plantation, FL 33318-9062	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
Claims Fiduciary	Employee Benefits Administration Committee	Medical Plan – United HealthCare Insurance Company Prescription Drug Program – Employee Benefits Administration Committee	Delta Dental of New York or CIGNA Dental Health, Inc.	EyeMed Vision Care

*Delta Dental (Traditional Option and Routine Option) does not guarantee or insure benefits under this Plan. These options are self-insured.

	Health Care Reimbursement Account	Life Insurance Plan	Long Term Disability (LTD) Benefit Plan
Formal Plan Name	Ameriprise Financial Health Care Reimbursement Plan	Ameriprise Financial Life Insurance Plan	Ameriprise Financial Long Term Disability (LTD) Benefit Plan
Plan ID Number	504	503	506
Plan Year	January 1 - December 31	January 1 - December 31	January 1 - December 31
Administration/ Funding	Administrative Services Agreement	Insured	Insured
Insurer or Claims Administrator	HealthEquity Claims Administrator P.O. Box 14053 Lexington, KY 40512	Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Overnight: Metropolitan Life Insurance Company Group Life Claims c/o Diversified Information Technologies 123 Wyoming Avenue Scranton, PA 18503	MetLife Disability Claims P.O. Box 14590 Lexington, KY 40511-4590
Claims Fiduciary	Employee Benefits Administration Committee	Metropolitan Life Insurance Company	Metropolitan Life Insurance Company

	Legal Assistance Plan	Dependent Care Reimbursement Account	Severance Pay Plan	Vacation Purchase Plan
Formal Plan Name	Ameriprise Financial Legal Assistance Plan	Ameriprise Financial Dependent Care Reimbursement Plan	Ameriprise Financial Severance Pay Plan	Ameriprise Financial Vacation Purchase Plan
Plan ID Number	507	505	511	508
Plan Year	January 1 - December 31	January 1 - December 31	January 1 - December 31	January 1 - December 31
Administration/ Funding	Contract Administration	Administrative Services Agreement	Claims Administration	Claims Administration
Insurer or Claims Administrator	MetLife Legal Director of Administration 1111 Superior Avenue Cleveland, OH 44114-2507	HealthEquity Claims Administrator P.O. Box 14053 Lexington, KY 40512	Ameriprise Financial, Inc. Employee Benefits Administration Committee 360 Ameriprise Financial Center Minneapolis, MN 55474	Ameriprise Financial, Inc. Employee Benefits Administration Committee 360 Ameriprise Financial Center Minneapolis, MN 55474
Claims Fiduciary	Employee Benefits Administration Committee	Employee Benefits Administration Committee	Employee Benefits Administration Committee	Employee Benefits Administration Committee

Appendix B: Timing and payment of health care claims and first-level appeals

Timing related to health care plans

Type of claim	Initial claim review	Plan notice of initial claim decision	Notice from Plan if Initial claim is incomplete	Claimant deadline to appeal decision	Plan notice of appeal decision
Urgent health claims	Must be decided no later than 24 hours after receipt of claim by the Plan	If additional information is requested, the Plan must make its determination within 48 hours after receiving the requested information	Must be provided 24 hours after receiving improper claim The claimant must be given at least 48 hours to provide the required information	180 days after receiving claim denial	72 hours after receiving appeal
Pre-service claims	Must be decided within 15 days after receipt of claim by the Plan May be extended 15 days due to circumstances beyond the control of the Plan (the Plan must notify the claimant within the initial 15-day period of the need for the extension and the date the Plan expects to make its decision)	If additional information is requested, the Plan must make its decision within 15 days of receipt of the information	The Plan will notify the claimant within 15 days if additional information is needed The claimant has 45 days from receipt of notice to provide required information	180 days after receiving claim denial	30 days after receiving appeal 15 days after receiving appeal if the Plan allows two levels of appeal

Type of claim	Initial claim review	Plan notice of initial claim decision	Notice from Plan if Initial claim is incomplete	Claimant deadline to appeal decision	Plan notice of appeal decision
Post-service health claims	Must be decided within 30 days after receiving claim May be extended 15 days due to circumstances beyond the control of the Plan (the Plan must notify the claimant within the initial 15-day period of the need for the extension and the date the Plan expects to make its decision)	30 days after receiving the initial claim 45 days after receiving the claim if the Plan needs more information and the Plan provides an extension notice during the initial 30-day period	The Plan will notify the claimant within 30 days The claimant must be given at least 45 days from receipt of the notice to provide the required information	180 days after receiving claim denial	60 days after receiving the appeal 30 days if the Plan allows two levels of appeal
Concurrent care claims	An adverse determination must be made in advance of any reduction or termination in treatment If treatment involves urgent care, a request to extend treatment must be decided within 24 hours of receipt of the claim (provided the request is made at least 24 hours prior to the expiration of treatment)	72 hours for urgent care claims 30 days for pre-service claims (15 days for each level of any two-level appeals process) 60 days for post-service claims (30 days for each level of any two-level appeals process)			

Timing related to non-health care plans

Plan name	Initial submission of claim by Employee	Initial claim determination by Claims Administrator	Deadline for first level appeal after receiving a denial	Determination of appeal
Long Term Disability	Within two years from start of disability	45 days from receipt of claim (105 days in special circumstances)	180 days from receipt of notice	45 days from receipt of appeal (90 days in special circumstances)
Life	As soon as reasonably possible	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice	60 days from receipt of appeal (120 days in special circumstances)
AD&D	20 days* for written notice; 90 days* for written proof	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice	60 days from receipt of appeal (120 days in special circumstances)
Dependent Care Reimbursement Account	The first six months following the end of the plan year in which the expense was incurred	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice (150 days in certain circumstances)	60 days from receipt of appeal (120 days in certain circumstances)
Legal Assistance (non-network claims only)	Up to 1 year after non-network service is complete	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice (150 days in certain circumstances)	60 days from receipt of appeal (120 days in certain circumstances)
Vacation Purchase	N/A	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice (150 days in certain circumstances)	60 days from receipt of appeal (120 days in certain circumstances)
Severance Pay	30 days from employment termination	90 days from receipt of claim (180 days in special circumstances)	60 days from date of notice (150 days in certain circumstances)	60 days from receipt of appeal (120 days in certain circumstances)

*Assumes number of days from the date you experience a covered loss under the AD&D Plan.

Appendix C: Affiliated employers

For purposes of the SPDs, affiliated employers include:

- American Enterprise Investment Services, Inc.
- Ameriprise Financial Services, LLC
- RiverSource Life Insurance Company
- RiverSource Life Insurance Co. of New York
- Ameriprise Trust Company
- Ameriprise Bank, FSB
- RiverSource Distributors, Inc.
- Columbia Management Investment Advisers, LLC
- Columbia Management Investment Services Corp.
- Columbia Wanger Asset Management, LLC
- Columbia Management Investment Distributors, Inc.
- Lionstone Partners, LLC

Appendix D: Definition of covered compensation for advisors and field leaders

This chart summarizes how covered compensation is defined for the following Health and Wellness Plans: Life Insurance, Long Term Disability and Accidental Death and Dismemberment.

During Open Enrollment, the Benefit System will reflect variable compensation for the current calendar year including coverage and costs. This information will be updated prior to the first payroll of the following year.

New Hires –

If during the hiring process a trailing twelve (T-12) amount is provided, that will be used to assign what the covered compensation rate will be for benefit purposes. This will be used for the first two full years of employment and will not change except for adjustments made to base draw or salary.

If no T-12 is provided during the hiring process, covered compensation will be based only on base salary or annual draw. As annual base salary or draw changes throughout the year it will change your covered compensation for benefit purposes as well. See Annual Covered Compensation Updates for information on future adjustments.

2023 new hire covered compensation assignment

T-12	Covered compensation assignment
Less than $100,000	$36,000
$100,000 but under $200,000	$48,000
$200,000 but under $300,000	$80,000
$300,000 but under $400,000	$119,000
$400,000 but under $500,000	$162,000
$500,000 but under $600,000	$209,000
$600,000 but under $700,000	$253,000
$700,000 but under $800,000	$292,500
$800,000 but under $900,000	$340,000
$900,000 but under $1,000,000	$389,500
$1,000,000 but under $1,100,000	$441,000
$1,100,000 but under $1,200,000	$494,500
$1,200,000 but under $1,300,000	$537,500
$1,300,000 but under $1,400,000	$594,000
$1,400,000 but under $1,500,000	$638,000
$1,500,000 but under $2,000,000	$805,000
$2,000,000 but under $2,500,000	$1,035,000
$2,500,000 but under $3,000,000	$1,265,000
$3,000,000 and above	$1,610,000

Annual Covered Compensation Updates*:

- Field Leaders & Advisors with less than two years of service as of December 31, 2022: Field Advisors and Leaders will maintain their assigned new hire covered compensation assignment based on the T-12 schedule in place on their DOH or base salary whichever was used at hire until the first January in which they have two (2) full calendar years of service.
    - As base salary or draw changes throughout the year, covered compensation will be adjusted (increase/decreased) to reflect that change.

- Field Leaders & Advisors with two or more calendar years of service as of January 1, 2023. Covered compensation will be updated in January 2023 as follows:
    - Current calendar year base or draw if applicable plus your prior 2-year average variable compensation (paid in 2021 and 2022). Variable comp is only updated annually.
    - As base salary or draw changes throughout the year, covered compensation will be adjusted (increase/decreased) to reflect that change.

Example:

John Doe DOH May 5, 2020
January 1, 2023 he will have 2 years (2021 and 2022) and 7 months (2020) of service
Covered Comp = Current Base (draw) + Average of 2021 + 2022 variable compensation

Compensation typically included in yearend variable compensation updates:

- Current Annual Base Pay/Draw
- Commissions on Sales
    - Financial Plans
    - Products
    - Risk Management Bonus (for sales of life/disability products)
- Recruiting Bonus for Field Leaders meeting their office recruiting goals
- Annual Incentive Awards (AIA)

Types typically not included:

- Speaker Bonus
- Training Bonus
- Recruiting Bonus given as part of hiring package
- Non-Cash bonuses (stocks, deferrals)

*Field Advisors or Leaders on an Unpaid Medical Leave will not have their annual covered compensation updated if on a leave in January.

Appendix E: Definition of covered compensation for Wholesalers

The chart below summarizes how covered compensation is defined for the following Health and Wellness Plans: Life Insurance, Long Term Disability and Accidental Death and Dismemberment.

Covered compensation for purposes of calculating Life Insurance, Accidental Death and Dismemberment and Long Term Disability benefits will include base salary and average commission paid in the prior year. Average commission will be determined for certain employees by using an average commission amount for all employees assigned to the same unique job code. The employee must also be in one of the following incentive plans:

Incentive Plan Code: 1	RiverSource Conservation
Incentive Plan Code: 7	Wealth Management
Incentive Plan Code: 17	RiverSource Distributors
Incentive Plan Code: 21	Experienced Advisor Recruiting
Incentive Plan Code: 33	Fixed Income Trading
Incentive Plan Code: 34	AM Institutional
Incentive Plan Code: 35	AM Intermediary

During Open Enrollment, the Benefit System will reflect your base salary and average commission compensation for the current calendar year including coverage level and costs.

The average commission amount will be updated each year in December. Any annual base salary changes throughout the year will change your covered compensation for benefit purposes as well.

To determine if you meet the criteria for this definition of covered compensation, please contact your HR Business Partner or contact the HR Service Center at 1.877.267.4748.