Versiti, Inc. Supplemental Medical Coverage Plan Summary Plan Description

Introduction

Versiti (the Employer) is pleased to provide the Versiti, Inc. Supplemental Medical Coverage Plan (the Plan) for Eligible Employees and Eligible Dependents. Under federal tax law, the Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan. The Plan is integrated with qualifying group major medical coverage that is not sponsored by Versiti (a Non-Versiti Plan). Only Employees and their Spouses or Dependents who stop coverage in Versiti's major medical plan and enroll in a Non-Versiti Plan are eligible for this Plan.

This booklet describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete Plan document and this booklet, the official Plan document will control. Definitions of capitalized terms used in this booklet are contained in Part V.

PART I. General Information About the Plan

I-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Employees, up to certain limits, for the cost of certain medical expenses. These expenses are referred to as eligible "Medical Care Expenses" and for purposes of the Plan include only your deductibles, coinsurance and copayments incurred under the Non-Versiti Plan in which you are enrolled. These reimbursements are generally excludable from your taxable income. See Section I-6 for a discussion of what qualifies as an eligible Medical Care Expense.

I-2. When did the Plan take effect?

The Plan became effective January 1, 2023.

I-3. Who can become a participant in the Plan?

Eligible Employees and Eligible Dependents (either a Spouse or other Dependent) may become Participants in the Plan. If you are an Employee or a Dependent or Spouse of an Employee, you are eligible to participate in the Plan if:

- You were participating in Versiti's major medical plan immediately prior to being offered coverage under this Plan (meaning you were either enrolled in Versiti coverage as of December 31, 2022 or you disenrolled in Versiti coverage upon experiencing a qualifying event such as annual open enrollment or gaining a Spouse and becoming eligible for coverage under their employer's plan after December 31, 2022);
- You enroll in a Non-Versiti Plan; and
- You provide sufficient proof of enrollment in a Non-Versiti Plan to the Administrator.

I-4. What Benefits are offered through the Plan?

Once you become a Participant, the Plan will maintain an "HRA Account" in the Employee's name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the Employee's HRA Account. For 2023, the maximum amount for a single Participant HRA Account is $9,100 and the maximum amount for a multiple Participant HRA

Account is $18,200. You will have access to the full contribution starting on the date you become a Participant in the Plan. Your HRA Account will be reduced by any amount paid for eligible Medical Care Expenses incurred by a Participant. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of each Plan Year, the unused amount (if any) in your HRA Account will be forfeited.

I-5. How will the Plan work?

The Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You must submit a claim to the Administrator, including a copy of the Explanation of Benefits issued to you by the Non-Versiti Plan, and provide any additional information requested by the Administrator;
- A request for payment must relate to eligible Medical Care Expenses incurred by a Participant during the time the individual was a Participant under this Plan; and
- A request for payment must be submitted by June 30 following the close of the Plan Year in which the eligible Medical Care Expense was incurred.

Eligible Medical Care Expenses can only be reimbursed under the Plan if the individual who incurred the expenses is a Plan Participant. A Participant cannot use the HRA Account to reimburse the medical expenses of a family member who is not enrolled in the Plan. For example, if the Employee is enrolled in Versiti's medical plan, but the Spouse (or other Eligible Dependent) is enrolled in a Non-Versiti Plan through his or her employer, then only eligible Medical Care Expenses of the enrolled Spouse (or other Eligible Dependent) can be reimbursed under the Plan.

Claims must be submitted in writing. The Administrator may require that Participants submit claims on a form provided by the Administrator. The claim must set forth:

- The individual(s) on whose behalf the eligible Medical Care Expenses were incurred;
- The nature and date of the eligible Medical Care Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such eligible Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Health FSA coverage, if any, for such eligible Medical Care Expenses will not apply until the HRA Account has been exhausted.

I-6. Are there any limitations on Benefits available from the Plan?

Only Medical Care Expenses are covered by the Plan. For purposes of the Plan, Medical Care Expenses ONLY include expenses for medical services and supplies that are eligible in-network covered expenses under the Non-Versiti Plan, but for which no benefit from the Non-Versiti Plan is payable (and you are responsible for payment) due to the operation of the deductible, copayment or coinsurance provisions of the Non-Versiti Plan.

I-7. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will become a Participant in the Plan effective as of (i) the date the eligibility requirements are met, or (ii) the first day of the later month indicated on your enrollment form, in accordance with procedures established by the Employer, but only if you are an Eligible Employee or Eligible Dependent on that day.

I-8. What if I cease to be an Eligible Employee or Eligible Dependent?

If you cease to be an Eligible Employee or Eligible Dependent because you are no longer covered by a Non-Versiti Plan, your participation will terminate when your Non-Versiti Plan coverage ends. If you cease to be an Eligible Employee or Eligible Dependent for any other reason, your participation in the Plan will terminate on the date on which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described below. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the HRA Account, provided that you comply with the reimbursement request procedures required under the Plan (see Section I-5 for more information on the reimbursement request process). Any unused portions will be not be available after termination of employment.

I-9. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can we continue to participate in the Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- The Employee’s termination from employment or reduction of hours;
- Divorce or legal separation from your Spouse;
- Becoming eligible to receive Medicare benefits;
- Your Dependent child ceasing to qualify as a Dependent.
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If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

I-10. Will I have any administrative costs under the Plan?

Generally, no. The Employer is currently bearing the entire cost of administering the Plan while you are an Employee.

I-11. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to terminate the Plan at any time. The Employer also reserves the right to amend the Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of HRA Account balances under this Plan.

I-12. Are my Benefits taxable?

The Plan is intended to meet requirements of existing federal tax laws, under which the Benefits that you receive under the Plan generally are not taxable to the Employee. However, the Employer cannot guarantee the tax treatment to any given Employee, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

I-13. What happens if my claim for Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA §502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to an internal appeal and, if applicable, an external review to an independent review organization.

D. Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your *internal* appeal rights. But you do not have to pursue *external* review in order to preserve

your right to file a lawsuit. (In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.)

E. What are the requirements of my internal appeal?

Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

F. Is there a deadline for filing my internal appeal?

Yes. Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. *If you do not file your internal appeal within this 180-day period, you lose your right to appeal.*

G. How will my internal appeal be reviewed?

Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

H. When will I be notified of the decision on my internal appeal?

The Administrator must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

I. What information is included in the notice of the denial of my internal appeal?

If your internal appeal is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount,

and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;

- The specific reason for the denial upon review;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring an external appeal or a civil action under ERISA §502(a). Any civil action under ERISA must be filed within one year of the Plan's denial of your appeal.

J. Do I have the right to seek a review of a denied claim to an external third party?

You have the right to an external review of the Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

K. What are the requirements of my external review?

A Participant has the right to an external review of the Administrator's denial of their internal appeal if their claimant's adverse appeal decision involves medical judgment or a rescission of coverage. Request for review by an external independent review organization (IRO) must be made by the Participant (or the Participant's authorized representative) in writing to the applicable claims administrator within 4 months of the Participant's receipt of notice of the Plan's final adverse mandatory appeal decision. If a Participant does not timely file a request for external review by the deadline, the only recourse will be to file a lawsuit under ERISA.

Upon request for external review, the Administrator will assign the request to an approved IRO. The IRO shall conduct a preliminary review of the request and respond to the Participant regarding eligibility for external review within the timeframe required under the Affordable Care Act. If the request is complete and eligible for consideration by an external IRO, then the IRO shall review the claim and respond to the Plan and the Participant in a manner and within a timeframe that complies with the requirements under the Affordable Care Act.

I-14. Who is the Administrator?

The Employer is the Administrator and the named fiduciary for the Plan.

I-15. May I elect to suspend or permanently opt out of my HRA Account?

Yes. If you participate in the Plan, you will be ineligible to make HSA contributions. You can remove the HRA as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your HRA Account before the beginning of that Plan Year. Whether you elect to suspend your HRA Account is up to you.

You may elect to suspend your HRA Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your HRA Account for a Plan Year, you agree to permanently forgo

reimbursements from your HRA Account for expenses that would otherwise count as Medical Care Expenses incurred during that Plan Year,. Medical Care Expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to the Administrator, no later than June 30 following the close of the Plan Year in which the Medical Care Expense was incurred.

In lieu of a suspension of your HRA Account, you may elect to permanently opt out of and waive any right to reimbursements from your HRA Account for expenses incurred after the election takes effect,. This opportunity will be offered at least annually by the Plan.

The Employer will not contribute to your HRA Account after any opt-out election takes effect or for any Plan Year for which you have suspended your participation in the Plan.

PART II. Administrative Information

The Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and Benefits. The Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Administrator may delegate some of its administrative duties to agents.

- Name of Plan: Versiti, Inc. Supplemental Medical Coverage Plan
- Employer: Versiti, Inc.
- Plan Sponsor:
  Versiti, Inc.
  638 N. 18th St.
  Milwaukee, WI 53233-2121
  (414) 937-6300
- Plan Sponsor’s federal tax identification number: 45-4675354
- Plan Administrator: the Plan Administrator is the same as the Plan Sponsor.
- Service of Process: the Plan’s agent for service of legal process is the Plan Administrator.
- Plan Type: the Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.
- Plan Number: 501
- Plan Year: January 1 through December 31
- Plan Funding: the Plan is paid for by the Employer out of the Employer’s general assets. There is no trust or other fund from which Benefits are paid.
- Third Party Administrator:
  Fidelity
  Fidelity Reimbursement Accounts Services
  PO Box 2703
  Fargo, ND 58108
  (833) 299-5089
  www.netbenefits.com/atwork

PART III. ERISA Rights

As a Participant in the Plan, you may be entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations (such as worksites and union halls) all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports;
- Obtain copies of all plan documents and other plan information upon written request to the Administrator (the Administrator may charge a reasonable amount for the copies); and
- Receive a summary of the Plan's annual information report (the Administrator is required by law to furnish each Participant with a copy of this summary annual report).

You are entitled to continue health care coverage under COBRA for yourself, your Spouse, or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation rights.

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

If your claim for a Benefit is ignored or denied 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 materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, then you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof regarding the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds that your claim is frivolous).

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

PART IV. HIPAA Privacy Rights

Group health plans, including the Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer that outlines its health privacy policies, including with regard to electronic PHI.

PART V. Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- *Administrator*. The Employer.
- *Benefits*. The reimbursement benefits for Medical Care Expenses described in the Plan.
- *COBRA*. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- *Code*. The Internal Revenue Code of 1986, as amended.
- *Compensation*. The wages or salary paid to an Employee by the Employer.
- *Dependent*. A dependent is an Employee's child as defined in Code §152(f)(1) who has not attained age 26, or a dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The Plan will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.
- *Eligible Dependent*. A Dependent or Spouse who is eligible to participate in the Plan, as provided in Section I-3.
- *Eligible Employee*. An Employee who is eligible to participate in the Plan, as provided in Section I-3.
- *Employee*. An Employee of the Employer who receives Compensation from the Employer. The term shall not include (1) any individual employed by the Employer at a location outside the United States; (2) an independent contractor; and (3) self-employed individuals.
- *Employer*. Versiti, Inc. or its successor(s), or a related employer who has adopted the Plan.
- *ERISA*. The Employee Retirement Income Security Act of 1974, as amended.
- *Health FSA*. A health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-5(a)(1).
- *HIPAA*. The Health Insurance Portability and Accountability Act of 1996, as amended.
- *HRA Account*. The recordkeeping account established in your name by the Employer on the basis of which your eligible Medical Care Expenses will be paid or reimbursed.
- *Medical Care Expenses*. See Section I-6 for a description of Medical Care Expenses.
- *Non-Versiti Plan*. Group major medical coverage that is not sponsored by Versiti. This coverage cannot include an HRA sponsored by the other employer. If an individual is enrolled in a health savings account in connection with the coverage, it will not qualify as a Non-Versiti Plan.
- *Participant*. An Eligible Employee or Eligible Dependent who has become and not ceased to be a Participant in the Plan.
- *Plan*. The Versiti, Inc. Supplemental Medical Coverage Plan.
- *Plan Year*. The 12-month period ending on December 31.
- *Spouse*. An individual who is treated as a spouse for federal tax purposes.

PART VI. Miscellaneous

Effect of the Plan on Your Employment Rights

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits

No Benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay, to the extent allowed by law.