HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY GROUP BENEFITS PLAN

Amended and Restated Effective as of January 1, 2018

Plan Number
501

TABLE OF CONTENTS

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ARTICLE I
RESTATEMENT OF PLAN

Section 1.1. Preliminary Information. Healthcare Information and Management Systems Society ("Company") established the Healthcare Information and Management Systems Society Medical Plan ("Plan") to provide certain medical benefits to Eligible Employees of the Employer.

Section 1.2. Restatement. The Plan is renamed the Healthcare Information and Management Systems Society Group Benefits Plan and amended and restated to include additional benefits under the Plan effective as of January 1, 2018.

ARTICLE II
DEFINITIONS AND CONSTRUCTION

Section 2.1. Construction and Governing Law.

The Plan will be construed, enforced, and administered and the validity thereof determined in accordance with the Act and in accordance with the laws of the State of Illinois when such laws are not inconsistent with the Act.

Words used herein in the masculine gender will be construed to include the feminine gender where appropriate and words used herein in the singular or plural will be construed as being in the plural or singular where appropriate.

Any differences or inconsistencies between the terms of this Plan and the documents incorporated by reference or the underlying Schedules of Benefits will be decided in favor of this Plan, unless specifically stated otherwise in the applicable section below.

Section 2.2. Definitions. When the initial letter of a word or phrase is capitalized herein, the meaning of such word or phrase will be as follows:

(a) "Act" means the "Employee Retirement Income Security Act of 1974," as amended from time to time.

(b) "Benefit Program" means each employee welfare benefit plan within the meaning of Section 3(1) of the Act that is sponsored by the Employer and each such Benefit Program incorporated by reference herein.

(c) "Claims Administrator" means a person, firm, or company, including an insurance company or other benefit provider, which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a Benefit Program, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. For purposes of Section 12.4 only, "Claims Administrator" may also mean the Plan Administrator or its designee.

(d) “Code” means the “Internal Revenue Code of 1986,” as amended from time to time.

(e) “Company” means Healthcare Information and Management Systems Society.

(f) **“**Compensation**”** means the total wages and salary, including bonuses, commissions and overtime pay, paid by the Company to a Participant for the Plan Year including:

(i) Any elective contribution made to any Code Section 401(k) plan maintained by the Company as the result of a salary reduction agreement entered into by the Participant for purposes of such plan (if any);

(ii) Any Company contributions made under Article X as the result of an Election Form/Salary Reduction Agreement completed and signed by the Participant and filed with the Plan Administrator.

(g) "Domestic Partner" means any person who is defined as a domestic partner under any Benefit Program.

(h) “Election Form/Salary Reduction Agreement” means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in pre-tax contributions under Article X by electing Salary Reductions to pay for any of the Benefit Programs. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Company to make Salary Reductions.

(i) “Eligible Employee” means any individual who is defined as an eligible employee under any Benefit Program, but excludes:

(i) an employee who is represented by any collective bargaining agent, or included in any collective bargaining unit recognized by the Employer, unless and until such Employer and the collective bargaining agent agree that the Plan will apply to such unit;

(ii) part-time employees working fewer than thirty (30) hours per week;

(iii) temporary or seasonal employees;

(iv) any person employed under a written agreement that provides that he or she will not be entitled to receive benefits under this Plan or any Benefit Program; and

(v) a person designated in good faith by the Employer as an independent contractor, regardless of whether such person is later determined to be a common law employee for any purpose.

(j) “Employer” shall mean any employer as designated by the Company as set forth in Schedule B.

(k) "Medical Benefits and/or Prescription Drug Benefits" means the benefits for medical coverage and/or prescription drug coverage, as applicable, that are referenced as "Medical Benefits," and/or "Prescription Drug Benefits" in Schedule A to this Plan.

(l) "Participant" means any Eligible Employee, dependent of an Eligible Employee or Qualified Beneficiary who meets the requirements for participation set forth in Article III and any applicable Benefit Program documents incorporated herein by reference, and who elects to become a Participant and has not for any reason become ineligible to participate further in the Plan.

(m) "Plan" means the employee welfare benefit plan, the terms of which are embodied herein, as amended from time to time, known as the "Healthcare Information and Management Systems Society Group Benefit Plan."

(n) "Plan Administrator" for the Plan means the Company, as provided in Section 10.1.

(o) "Plan Year" means the twelve (12) month period beginning on January 1 and ending on the following December 31.

(p) "PPACA" means the Patient Protection and Affordable Care Act of 2010.

(q) "Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

(r) "Protected Health Information" means "protected health information," as defined at 45 CFR §164.501, which generally means information (including demographic information) that (i) identifies an individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(s) "Rescission" or "Rescind" means a cancellation or discontinuance of coverage for Medical Benefits and/or Prescription Drug Benefits that has retroactive effect. A Rescission does not include the cancellation or discontinuance of coverage for Medical Benefits and/or Prescription Drug Benefits that (i) has only a prospective effect, (ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) toward the cost of such coverage or due to administrative delays in processing, or (iii) is initiated by the individual and the Company does not take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual.

(t) "Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Company to pay for one or more of the Benefit Programs, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (*i.e.,* on a pre-tax basis).

(u) "Security Regulations" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

ARTICLE III
ELIGIBILITY, PARTICIPATION, AND BENEFITS

Section 3.1. Eligibility. The class or classes of employees eligible to participate in the Plan are as set forth in the definition of "Eligible Employee" and the applicable Benefit Program documents, the provisions of which are incorporated herein by reference. For purposes of determining eligibility under the Plan, the classification to which an individual is assigned by the Employer will be final and conclusive, regardless of whether a court or other entity subsequently finds that such individual should have been assigned to a different classification. Dependents of Eligible Employees meeting the definition of dependent under the applicable Benefit Program documents are eligible to participate in the Plan as set forth in the applicable Benefit Program documents, the provisions of which are incorporated herein by reference.

Section 3.2. Participation. An Eligible Employee and dependents of Eligible Employees that satisfy the eligibility conditions specified in Section 3.1 will become eligible to participate in the Plan provided the Eligible Employee and the dependents of Eligible Employees enroll and make the required elections on the forms required by the Plan Administrator within the time and in the manner determined by the Plan Administrator. Such participation in the Plan will begin at the time determined by the Plan Administrator according to the terms of the applicable Benefit Program.

Section 3.3. Employee Benefits. The Company will provide the applicable Benefit Programs to Participants pursuant to the Plan and the terms and conditions of each applicable Benefit Program. No Eligible Employee or his or her dependents will have any vested interest in any Benefit Program under the Plan.

Section 3.4. Insured Policies and Benefit Contracts Providing Employee Benefits.

(a) The Company may, but is not obligated to, enter into insurance contracts issued by any insurance company qualified to do business in the United States or enter into contracts with any other benefit provider, including but not limited to a health maintenance organization ("HMO") or a preferred provider organization ("PPO"), to provide benefits specified under Section 3.1. Any such benefit contracts or policies may be changed by mutual agreement between the Company and the insurance company or benefit provider at any time and from time to time. The Company will be the owner and policyholder of any such benefit contracts or policies. All insured Benefit Programs provided under this Plan are listed on Schedule A, which may be updated from time to time.

(b) Any Benefit Program set forth in Schedule A will be limited to the benefits provided under any benefit contract or policy, as amended from time to time. Except as may be otherwise specifically provided in the Plan, the rights, duties, obligations, and responsibilities of the Participating Employer, and the Eligible Employees and their

dependents concerning the benefits will be limited to such rights, duties, obligations, and responsibilities as may be set forth in any such benefit contract or policy, as amended from time to time.

Section 3.5. Uninsured Benefit Programs. From time to time, the Company or a Participating Employer may provide benefits which are not fully insured to Eligible Employees, as set forth in Schedule A.

Section 3.6. Incorporation of All Relevant Benefit Program Documents. All written documents relating to the Benefit Programs are incorporated herein by reference, and made a part hereof.

Section 3.7. Termination, Addition, and Modification of Benefit Programs. The Company or its duly authorized officer may terminate, add, or modify any Benefit Program under the Plan. Any such additional benefit will be subject to all of the terms and conditions of this Plan.

ARTICLE IV
CONTINUATION OF COVERAGE

The Benefit Programs under the Plan will comply with all requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), to the extent applicable and required by applicable law, and as described below and in the Benefit Program. Certain Benefit Features also provide continuation coverage to Domestic Partners; however, such coverage is not provided pursuant to a legal requirement under COBRA.

Section 4.1. Right to Continuation Coverage. A Qualified Beneficiary may elect to continue group health coverage under the Plan in accordance with the applicable Benefit Program after a Qualifying Event. Only those individuals who are covered under the group health coverage under the applicable Benefit Program on the day before the event which triggered termination of coverage (including dependents born to or placed for adoption with the Eligible Employee during the continuation coverage) are eligible to elect this continuation coverage.

Section 4.2. Qualified Beneficiary. Only Qualified Beneficiaries may elect continuation coverage under the group health coverage under the applicable Benefit Program. For purposes of this Article, a "Qualified Beneficiary" is a person who is covered under the group health coverage under the applicable Benefit Program on the day before a Qualifying Event (including dependents born to or placed for adoption with the Eligible Employee during the continuation coverage) who is:

(a) an Eligible Employee who is covered under the applicable Benefit Program (a "Covered Employee");

(b) a spouse of a Covered Employee;

(c) a Domestic Partner of a Covered Employee; or

(d) a dependent child of a Covered Employee.

Section 4.3. Qualifying Events. The right to continued coverage is triggered by any of five (5) Qualifying Events, which, but for the continued coverage, would result in a loss of coverage under the group health coverage under the applicable Benefit Program. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the Qualifying Event or an increase in the premium or contribution that must be paid by a Covered Employee. For purposes of this Article, a "Qualifying Event" occurs upon:

(a) the death of the Covered Employee;

(b) the termination (other than by reason of gross misconduct) of the Covered Employee's employment, or reduction of hours of a Covered Employee, that would result in a termination of coverage under the group health coverage under the applicable Benefit Program;

(c) the divorce or legal separation of the Covered Employee from the Covered Employee's spouse;

(d) the termination of the Domestic Partner relationship between the Covered Employee and the Domestic Partner;

(e) the Covered Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or

(f) a child of the Covered Employee ceasing to be a dependent child under the eligibility requirements of the group health coverage under the applicable Benefit Program.

If any of the above-mentioned Qualifying Events occur to a Qualified Beneficiary, then that Qualified Beneficiary may elect to continue coverage under the group health coverage under the applicable Benefit Program.

Section 4.4. Election of Continuation Coverage. Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event will have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage. The election period will begin on or before the date that the Qualified Beneficiary would lose coverage under the group health coverage under the applicable Benefit Program due to the Qualifying Event, and will not end before the date that is sixty (60) days after the later of: (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event or (ii) the date on which notice of the right to continued coverage is sent by the Plan Administrator or its designee. The election of continuation coverage must be made on a form provided by the Plan Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Plan Administrator.

Section 4.5. Period of Continuation Coverage.

(a) In the case of a Qualifying Event caused by termination of employment or reduction in hours, the Qualified Beneficiary may elect to extend coverage for a period of up to eighteen (18) months from the date of the Qualifying Event, unless it ends earlier as described under Section 4.6; provided, however, with respect to the extension of coverage under the health flexible spending account of the Healthcare Information and Management Systems Society Flexible Benefits Plan, continuation coverage will extend only until the end of the calendar year in which the Qualifying Event occurs.

(b) If a second or additional Qualifying Event occurs during the initial eighteen (18) month continuation coverage period or during a twenty-nine (29) month maximum coverage period in the case of a disability, the Qualified Beneficiary may elect to extend the continuation coverage period for a period of up to thirty-six (36) months from the date of the earlier Qualifying Event. If the Covered Employee became entitled to Medicare within eighteen (18) months prior to a Qualifying Event caused by termination of employment or reduction in hours, Qualified Beneficiaries (other than the Covered Employee) may elect to extend coverage for a period of thirty-six (36) months from the date of the Covered Employee's entitlement to Medicare benefits.

(c) If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within sixty (60) days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced, or was determined to be a disability before the sixty (60) days of the initial eighteen (18) month continuation coverage period), coverage may be continued for all Qualified Beneficiaries for a period of up to twenty-nine (29) months from the date of the Qualifying Event, if notice of such disability determination is provided by the Qualified Beneficiary to the Plan Administrator or its designee within eighteen (18) months of the Qualifying Event and within sixty (60) days after the latest of: (i) the date the Qualified Beneficiary is determined to be disabled by the Social Security Administration, (ii) the date the Qualifying Event occurs, (iii) the date the Qualified Beneficiary loses or would lose coverage, or (iv) the date the Qualified Beneficiary is notified of his or her notice obligation. The Qualified Beneficiary is responsible for notifying the Plan Administrator or its designee within thirty (30) days of the later of: (i) the date of the final determination that the Qualified Beneficiary is no longer disabled or (ii) the date the Qualified Beneficiary is notified of his or her notice obligation.

(d) In the case of any Qualifying Event not otherwise described in subsections (a), (b), and (c), the Qualified Beneficiary may elect to extend coverage for a period of up to thirty-six (36) months from the date of the Qualifying Event, unless it ends earlier as described under Section 4.6.

Section 4.6. End of Continuation Coverage. Continuation coverage will end earlier than the period elected if:

(a) timely payment of premiums for the continuation coverage is not made;

(b) the Qualified Beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise;

(c) the Qualified Beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;

(d) the Participating Employer ceases to provide any group health plan to any employee;

(e) the Covered Employee ceases to be disabled, if continuation coverage is due to the disability; or

(f) the period of continuation coverage expires.

Notwithstanding, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

Section 4.7. Cost of Continuation Coverage. The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as "premium." The premiums are payable on a monthly basis. After a Qualifying Event, a notice will be provided which will specify the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, will only be considered to be timely if made within thirty (30) days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within forty-five (45) days after the date of election. Notice will be given which will specify the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

Section 4.8. Notification Requirements.

(a) General Notification to Covered Employee and Spouse/Domestic Partner. The group health coverage under the applicable Benefit Program will provide, at the time of commencement of coverage, written notice to each Covered Employee and to the spouse or the Domestic Partner of the Covered Employee (if any) of their rights to continuation coverage. This notice may be furnished by a single notice addressed to both a Covered Employee and his/her spouse or Domestic Partner if they reside at the Covered Employee's address and the spouse's or Domestic Partner's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided under this subsection (a). No separate notice is required to be sent to a dependent child who shares a residence with a Covered Employee or his/her spouse or Domestic Partner. This notice will be provided to a Covered Employee and his or her spouse or Domestic Partner not later than the earlier of: (i) ninety (90) days after the Covered Employee's coverage under the Plan begins or (ii) the date the Covered Employee

would otherwise receive an election form due to a Qualifying Event (see subsection (d) below).

(b) Employer Notification to Plan Administrator. The Employer will notify the Plan Administrator or its designee in the event of a Covered Employee's death, termination of employment, reduction in hours, or entitlement to Medicare benefits within thirty (30) days after the later of: (i) the date of the Qualifying Event or (ii) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event.

(c) Covered Employee/Qualified Beneficiary Notification to Plan Administrator. In the case of (i) a divorce or legal separation of the Covered Employee from the Covered Employee's spouse or termination of the Domestic Partner relationship between the Covered Employee and the Domestic Partner, as applicable, (ii) a child ceasing to be a Dependent child under the eligibility requirements of the group health coverage under the applicable Benefit Program, (iii) a second qualifying event, or (iv) notice of disability entitlement or cessation of disability, the Covered Employee or Qualified Beneficiary must notify the Plan Administrator or its designee as soon as possible but not later than sixty (60) days after the later of: (i) the date of such Qualifying Event, (ii) the date that the Qualified Beneficiary would lose coverage due to such Qualifying Event, or (iii) the date the Qualified Beneficiary is notified of both his or her responsibility to provide notice and the Plan's procedures for providing such notice. Failure to provide such timely notice will result in the loss of any right to elect continuation coverage.

The Covered Employee, Qualified Beneficiary, or representative acting on behalf of the Covered Employee or Qualified Beneficiary may provide such notice. Notice of one individual will satisfy responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

(d) Plan Administrator Notification to Qualified Beneficiary. The Qualified Beneficiary will be notified by the Plan Administrator or its designee of their right to elect continuation coverage:

(i) in the event of the Covered Employee's death, termination, reduction in hours or entitlement to Medicare benefits, and

(ii) in the event of divorce or legal separation of the Covered Employee from the Covered Employee's spouse, the Covered Employee's disability, or in the event of a child ceasing to be a dependent child under the generally applicable requirements of the group health coverage under the applicable Benefit Program,

within fourteen (14) days after the date on which the Plan Administrator or its designee was notified of these Qualifying Events. In addition, if a Covered Employee or dependent is not entitled to receive continuation coverage, he or she will be notified of this and will be provided with an explanation as to why he or she is not entitled to this continuation coverage. Any notification to a Qualified Beneficiary who is the spouse or Domestic Partner of the Covered Employee will be treated as a notification to all other Qualified Beneficiaries residing with such spouse or Domestic Partner at the time such notification is made.

(e) The Plan Administrator or its designee will provide notice to each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum coverage period applicable to such Qualifying Event, as soon as practical following the Plan Administrator's determination that continuation coverage should terminate.

Section 4.9. Continuation Health Benefits Provided. The continuation coverage provided to a Qualified Beneficiary who elects continued coverage will be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage with respect to whom a Qualifying Event has not occurred. If coverage is modified under the group health coverage for any group of similarly situated beneficiaries, such coverage will also be modified in the same manner for all individuals who are Qualified Beneficiaries under the group health coverage. Continuation coverage may not be conditioned on evidence of good health. If the group health coverage under the applicable Benefit Program provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the group health plan coverage under the applicable Benefit Program, or to add or eliminate coverage of family members, the group health plan coverage will provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

ARTICLE V
FAMILY AND MEDICAL LEAVE ACT

The Plan, through the appropriate Benefit Programs under the Plan, will provide continuation coverage consistent with the provisions of the Family and Medical Leave Act of 1993, as amended ("FMLA"). Under the FMLA, any Eligible Employee entitled to FMLA leave may continue his or her health benefit coverage under the applicable Benefit Program, and any dependent's coverage, under this Plan as if continuously employed during the entire FMLA leave period provided the Eligible Employee continues to pay the required Employee contributions; otherwise health coverage will be reinstated when the Eligible Employee returns from the FMLA leave. Certain limitations stated below may apply. No new conditions or waiting periods will apply to the coverage upon your return to work. The Eligible Employee's right to continue coverage for non-health benefits will be governed by the right to continue such coverage during non-FMLA-type leaves. You may be entitled to FMLA leave for the following reasons:

- birth of a child, and to care for such child;
- placement of a child with you for adoption or foster care;
- to care for a spouse, Domestic Partner, child, or parent (with a serious health condition as defined under the FMLA);
- a serious health condition that makes you unable to perform your job functions;
- a "qualifying exigency" (as defined under the FMLA) arising out of a covered family member's call to active duty in the military. In addition, any spouse, Domestic Partner,

son, daughter, parent, or nearest blood relative ("next of kin") will be granted leave to care for a "covered service member" with a "serious illness or injury."

The Employer is responsible for determination for your eligibility, rights, or the length of leave period for FMLA, and will notify the Plan for purposes of continuing your coverage under this Plan.

ARTICLE VI
OTHER GROUP HEALTH PLAN MANDATES

Section 6.1. Health Insurance Portability and Accountability Act of 1996. Any group health plan, as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which is incorporated into this Plan as a Benefit Program and which is obligated to meet the requirements of HIPAA (hereinafter referred to in this Article as "affected Benefit Program") will comply with HIPAA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Program. Such compliance will include the following:

(a) Special Enrollment Periods.

(i) Notwithstanding any other provisions in this Plan or in the affected Benefit Program to the contrary, eligible individuals will be entitled to request enrollment in the affected Benefit Program during the following special enrollment periods: If Eligible Employees and their dependents who declined coverage under this Plan because of other health insurance or group health plan coverage and subsequently lose such other coverage, Eligible Employees will have at least thirty (30) days after the date of such loss of coverage to request enrollment in the affected Benefit Program for themselves and their dependents; If Eligible Employees have a new dependent as a result of marriage, birth, adoption, or placement for adoption, Eligible Employees will have at least (30) days after the date of the marriage, birth, adoption, or placement for adoption to request enrollment in the affected Benefit Program for themselves and their dependents; and

(ii) Eligible Employees and their dependents, who are not enrolled in an affected Benefit Program, may elect to enroll if:

(i) such eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act, the coverage under such a plan is terminated as a result of loss of eligibility for such coverage, and the eligible individual requests coverage under any affected Benefit Program no later than sixty (60) days after the date of such loss of coverage; or

(ii) the eligible individual becomes eligible for assistance, with respect to coverage under an affected Benefit Program, under such Medicaid plan or state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan) and the eligible individual requests coverage under the affected Benefit Program

not later than sixty (60) days after the date the eligible individual is determined to be eligible for such assistance; and

(iii) the Eligible Employee is also enrolled in the Plan or any affected Benefit Program.

(b) Discrimination Based on Health Status-Related Factors Prohibited. Notwithstanding any other provisions in this Plan or in the affected Benefit Program to the contrary, no person will be discriminated against in terms of eligibility, continued eligibility, or level of required employee contribution based on the following health status-related factors: (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information, as that term is defined in HIPAA; (vii) evidence of insurability (including conditions arising out of acts of domestic violence); or (viii) disability.

Section 6.2. Mental Health Parity Acts. Any group health plan, as that term is defined under the Act, which is incorporated into this Plan as a Benefit Program, which provides both medical and surgical benefits and mental health or substance abuse disorder benefits, and which is obligated to meet the requirements of the Mental Health Parity Act of 1996 and the January 1, 2010, the Paul Wellstone and Pete Domenic's Mental Health Parity and Addiction Equity Act of 2008, (collectively "Mental Health Parity Acts"), will comply with the requirements of the Mental Health Parity Acts, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Program.

Benefit Programs may use cost containment methods, including cost-sharing, limits on the number of visits or days of coverage, or terms and conditions that relate to the amount, duration and scope of mental health benefits. The benefits and services included in any coverage for "mental health benefits" will be determined by the applicable Benefit Program detailing such coverage.

Section 6.3. Newborns' and Mothers' Health Protection Act of 1996. Any group health plan, as that term is defined in HIPAA, which is incorporated into this Plan as a Benefit Program and which is obligated to meet the requirements of the Newborns' and Mothers' Health Protection Act of 1996 will comply with such act, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Program. As part of such compliance, no affected Benefit Program, or health insurance funding such affected Benefit Program, may (i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following normal vaginal delivery, or less than ninety-six (96) hours following a caesarean section or (ii) require that a provider obtain authorization from the Plan, affected Benefit Program, or insurance issuer for prescribing a length of stay not in excess of the above periods.

Section 6.4. Women's Health and Cancer Rights Act of 1998. Any group health plan, as that term is defined under the Act, which is incorporated into this Plan as a

Benefit Program, which is obligated to meet the requirements of the Women's Health and Cancer Rights Act of 1998 will comply with such act, as amended from time to time, and any regulations issued thereunder, and to the extent not otherwise inconsistent with any federal law or regulation governing such Benefit Program.

If group health plan coverage offered under a Benefit Program provides medical and surgical benefits with respect to a mastectomy, it will include coverage for the following medical and surgical benefits for an individual who is receiving group health plan benefits under such Benefit Program in connection with a mastectomy and who has elected breast reconstruction:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined in consultation with the attending physician and patient. Coverage for breast reconstruction and related services associated with a mastectomy will be subject to deductibles, copayments, coinsurance amounts, pre-certification and utilization review requirements that are consistent with those that apply to other benefits offered under such Benefit Program.

Section 6.5. Genetic Information Nondiscrimination Act of 2008. Any group health plan which is incorporated into this Plan as a Benefit Program and which is obligated to meet the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA"), will comply with GINA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Program. This Plan or any affected Benefit Program under this Plan may not request, require, or purchase genetic information of any individuals prior to enrollment in the Plan or affected Benefit Program, for determination of eligibility (including enrollment and continued eligibility) for benefits, premium adjustments, application of any pre-existing condition exclusion, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits under this Plan or the affected Benefit Program.

Section 6.6. Health Benefit Program Coverage of Dependent Children in Cases of Adoption. In any case in which a Benefit Program provides health coverage for dependent children of Participants or beneficiaries, such Benefit Program will provide benefits to dependent children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in case of dependent children who are natural children of Participants or beneficiaries under a Benefit Program, irrespective of whether the adoption has become final. The term "Child" means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption. The term "Placement," "Placement For Adoption," or being "Placed For Adoption", in connection with any

Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

Section 6.7. Compliance with the PPACA. Group health plans (such as the Medical Benefits and Prescription Drug Benefits that are identified in Schedule A to this Plan) are required to comply with the PPACA. PPACA makes a number of changes to existing Federal laws that impact group health plans, such as the Act and the Code. The Plan coverages identified in the preceding sentences will comply with all of their responsibilities, as required under the PPACA.

Section 6.8. Prohibitions on Rescissions of Medical Benefit and/or Prescription Drug Benefit Coverage. With respect to Medical Benefit and/or Prescription Drug Benefit coverage, the Plan and any applicable Benefit Program will comply with Section 2712 of the Public Health Service Act, as added by Section 1001 of PPACA and incorporated into Section 715 of the Act, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Plan and any applicable Benefit Program will not Rescind coverage for Medical Benefits and/or Prescription Drug Benefits with respect to a Participant, except in the case where the Participant (or the person seeking coverage on behalf of the Participant) has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact (including but not limited to a enrolling an ineligible individual or otherwise failing to comply with the Benefit Programs requirements).

The Plan and any applicable Benefit Program will provide thirty (30) days advance written notice to each such Participant who would be affected before such coverage is Rescinded. For purposes of this Section, a Rescission is a cancellation or discontinuance of Medical Benefit and/or Prescription Drug Benefit coverage that has retroactive effect. Notwithstanding the foregoing, the Plan may still cancel or discontinue Medical Benefit and/or Prescription Drug Benefit coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this Section will prohibit the Plan or any applicable Benefit Program from cancelling or discontinuing such coverage prospectively for any reason provided under the Plan or any applicable Benefit Program.

ARTICLE VII
PROTECTED HEALTH INFORMATION

This Article applies to the Plan only to the extent that the Plan or any of the Welfare Plans constitute a "health plan" under 45 CFR 160.103 that uses or discloses "protected health information" ("PHI") as those terms are defined under 45 CFR 164.501 and such Welfare Plans do not have its own HIPAA procedures. Section 7.4 shall apply only to the extent that this Plan transmits or maintains "electronic protected health information" as that term is defined in 45 CFR §164.501. For purposes of this Article, terms defined in HIPAA or 45 CFR §§ 160 and 164 ("HIPAA Privacy Rules"), but not in this Plan, shall be interpreted and administered in accordance with those provisions and all references to HIPAA and to the provisions 45 CFR §§ 160 and 164 shall be to the relevant provisions as amended by the Health Information Technology for Economic

and Clinical Health Act ("HITECH Act") portion of the American Recovery and Reinvestment Act of 2009.

Section 7.1. Uses and Disclosures of PHI.

(a) Permitted and Required Uses and Disclosures. The Plan Administrator, the Claims Administrator and any of their delegates or designees shall use and disclose PHI to the extent that it determines that such use or disclosure:

(i) is needed for the "payment" of claims under the Plan, the "treatment" of Participants or Beneficiaries under the Plan, or the "health care operations" of the Plan, as such terms are defined in 45 CFR §164.501;

(ii) is required or permitted by law;

(iii) has been authorized in accordance with 45 CFR §164.508;

(iv) is appropriate under Section 7.2;

(v) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(vi) is made to a person involved in the care of the Participant or Beneficiary, as determined by the Plan Administrator or Claims Administrator (as applicable) or the Privacy Officer.

(b) Disclosure to the Employer. Unless specifically permitted by law, the Plan Administrator, any Claims Administrator and any of their delegates or designees shall not disclose any PHI to any Employer unless:

(i) such disclosure is to enable the Employer to perform "plan administration functions" under 45 CFR § 164.504(a); and

(ii) the Employer has certified that this Plan document incorporates the requirements of 45 CFR § 164.504(f)(2)(ii) and the Participating Employer has agreed to comply with these requirements.

(c) No Other Uses or Disclosures. In no event shall the Company, the Employer, the Plan Administrator, any Claims Administrator and any of their delegates or designees use or disclose PHI for employment-related actions and decisions, in connection with any other benefit plan, or for any other purpose other than as required by law or as required or permitted by this Plan document.

(d) Business Associates. To the extent required by law, the Plan Administrator shall not disclose PHI to a Claims Administrator or any other individual or entity that constitutes a "business associate" under 45 CFR § 160.103, except as provided under a "business associate agreement" that meets the requirements of 45 CFR § 164.504(e).

(e) Minimum Necessary. In no event shall the use or disclosure of PHI by the Plan Administrator or its designee exceed the amount reasonably determined by the Privacy Officer to be the minimum use or disclosure necessary for the intended purposes of the use or disclosure. To the extent allowed by 45 CFR § 164.514(d)(3)(iii), the Privacy Officer may rely on a requested disclosure as the minimum disclosure necessary.

(f) Separation of Plan Administration and Employer. Access to PHI for Plan administration purposes shall be limited to (i) the Privacy Officer and (ii) any other individual who may be designated from time to time by the Privacy Officer to assist with Plan administration. None of the individuals identified in the preceding sentence shall have access to PHI, except as reasonably necessary to perform the Plan administrative functions which are assigned or delegated to them. In case of any delegation, the individual to whom duties are assigned shall be required to comply with the provisions of this Article. Beyond the individuals identified in this Section, no other individuals employed by the Employer shall have access to PHI.

(g) Privacy Officer and Contact Person. The "Privacy Officer" of the Plan, who shall be appointed by the Company, shall be responsible for the development and implementation of the Plan's privacy policy (as provided in 45 CFR § 164.530) and administrative procedures. The contact person for the Plan, who shall be appointed by the Company, shall be responsible for responding to Participant requests for additional information about such policies and procedures. The Privacy Officer may delegate its duties as described in this Section to the contact person, an individual designated as having access to PHI in accordance with Section 7.1, or a business associate (including a Claims Administrator), to the extent necessary and appropriate for the proper and efficient administration of the Plan and compliance with the HIPAA Privacy Rules.

(h) Noncompliance. Any individual identified in Section 7.1 who fails to comply with the Plan's privacy policy and related procedures shall be subject to the same disciplinary rules and procedures that apply to breaches of the employment policies of the Participating Employer. In the event of non-compliance with any of the provisions set forth in this Section,

(i) the Privacy Officer will address any complaint promptly and confidentially. The Privacy Officer first will investigate the complaint and document his or her investigation efforts and findings.

(ii) if PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with this Section, the Privacy Officer shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(i) Right to Revise Policy and Notice. To the fullest extent allowed by 45 CFR § 164.520(b)(1)(v), the Privacy Officer shall be permitted to modify the privacy policy and notify Participants of those modifications.

(j) More Stringent State Law. This Plan shall be administered and interpreted to comply with any applicable state law, except to the extent that such state law is preempted by ERISA or HIPAA.

(k) Cooperate with HHS. The Privacy Officer shall disclose PHI, and its internal practices, books, and records, as required, to the Department of Health and Human Services for the purpose of investigating or determining compliance with 45 CFR §§ 160 and 164, and the statutory provisions which they interpret.

Section 7.2. Individual Rights of Participants. Where this Article applies, it shall apply to the following individual rights of Participants and their authorized representatives with respect to their own PHI: (i) the right to access and copy PHI under 45 CFR §164.524; (ii) the right to amend PHI under 45 CFR § 164.526; (iii) the right to receive an accounting of disclosures of PHI under 45 CFR § 164.528; (iv) the right to request restrictions on uses and disclosures of PHI under 45 CFR § 164.522(a); and (v) the right to request confidential communications under 45 CFR § 164.522(b).

To the extent the Plan uses or maintains an electronic health record (as defined in HIPAA) with respect to PHI, an individual has the right to receive an accounting of disclosures of such electronic health records made by an Employer in the three (3) years prior to the date on which the accounting is requested, including: (i) to carry out health care treatment, payment and health care operations, (ii) any disclosures not permitted by the Privacy Rule, (iii) any disclosures an Employer makes pursuant to a "public policy" purpose, (iv) any disclosures required by law, and (v) any disclosures made pursuant to an administrative or judicial order, subpoena, discovery request, qualified medical child support order, or workers' compensation program.

Each Business Associate of the Plan is required, by the terms of its contract to provide Plan services, to ensure that these individual rights provisions are honored with respect to any Participant PHI that such Business Associate uses or maintains.

Section 7.3. Additional Obligations.

(a) Compliance by Agents. Any agents, including subcontractors, to whom the Plan Administrator provides PHI received from the Plan must agree to the same restrictions and conditions that apply to the Plan. Any contract between the Plan Administrator or the Company and any agents or subcontractors providing services to the Plan which meet the definition of "business associate" under 45 CFR § 160.103 must comply with the requirements of 45 CFR § 164.504(e).

(b) Report Improper Uses or Disclosures. If the Company or Plan Administrator becomes aware of any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this Plan document or under 45 CFR §§ 160 and 164, they will report such use or disclosure to the Privacy Officer or its designee.

(c) Breaches. Following the discovery of a breach of unsecured PHI, the Plan will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of a breach, in accordance with 45 C.F.R Section 164.404 as amended, and will notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408 as amended. For a breach of unsecured PHI

involving more than 500 residents of a State or jurisdiction, the Plan will notify the media in accordance with 45 C.F.R. Section 164.406 as amended. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

(d) Destroy PHI or Retain Protections. The Company shall return or destroy all PHI received from the Privacy Officer that the Company still maintains in any form at the time when it is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make return or destruction infeasible.

(e) Restrictions. The Company shall ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees in writing to the same restrictions and conditions and to implement reasonable and appropriate safeguards to protect electronic PHI.

Section 7.4. Health Information Security.

(a) Security Officer. The "Security Officer" of the Plan shall be appointed by the Company. The Security Officer shall be responsible for the development and the implementation of the Plan's security policy, as provided in 45 C.F.R. Section § 164.308(a)(2).

(b) Security Rule Compliance. The Company shall: (i) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Plan; (ii) ensure that adequate separation as required by 45 C.F.R. Section § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures; (iii) require any agent, including a subcontractor, to whom it provides this information to agree to implement reasonable and appropriate security measures to protect the electronic PHI; (iv) report to the Plan any successful unauthorized use, access, disclosure, modification, or destruction of electronic PHI or interference with system operations in an information system containing PHI of which it becomes aware; (v) report as frequently as necessary to the Plan the aggregate number of unsuccessful, unauthorized attempts to use, access, disclose, modify, or destroy electronic PHI or interfere with system operations in an information system containing PHI of which it becomes aware; and (vi) implement and maintain policies and procedures relating to these safeguards.

Section 7.5. Supersession of Inconsistent Provisions. This Article will supersede the provisions of any Health Benefit Program to the extent those provisions are inconsistent with the provisions of this Article.

ARTICLE VIII
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

Section 8.1. USERRA Continuation Coverage.

(a) An Eligible Employee may be entitled to reemployment and other rights after a period of "Uniformed Services" under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), including certain contributions and service credits under the applicable Benefit Programs that are subject to USERRA. For purposes of USERRA, "Uniformed Services" includes the Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service Commission Corps, as well as the reserve components of each of these services. Training or service in the Army National Guard or the Air National Guard, certain types of service by members of the National Disaster Medical System, and certain types of service by certain members of the Reserve Officers' Training Corps also constitutes service in a "Uniformed Service." Each Benefit Program will be administered in compliance with the requirements of USERRA to the extent applicable.

(b) To be eligible for such USERRA benefits, before leaving for military service, the Eligible Employee is generally required to give the Employer advance notice that such Eligible Employee is leaving the job for service in the Uniformed Services. When such Eligible Employee returns from military service, he or she must timely submit an application for reemployment with the Employer and request information regarding such Eligible Employee's reemployment rights. Time limits for returning to work will depend on the length of time of such military service.

Section 8.2. Continuation of Coverage. If an Eligible Employee is absent from a position of employment with the Participating Employer by reason of service in the uniformed services and was covered under a group health plan under a Benefit Program that is required to provide continuation coverage under 38 U.S.C. § 4317 immediately prior to his or her absence due to service in the uniformed services, such Eligible Employee will then be entitled to elect to continue health care coverage under the applicable Benefit Program for the Eligible Employee and his or her covered dependents for a period equal to the lesser of (1) twenty-four (24) month period beginning on the date on which such Eligible Employee is absent from employment with the Participating Employer by reason of service in the uniformed services or (2) the period beginning on the date the Eligible Employee's absence for service in the uniformed services begins, and ending on the day following the date on which the Eligible Employee fails to apply for or return to a position of employment with the Participating Employer as determined pursuant to USERRA Section 4312(e). Eligible Employees may elect to discontinue coverage under the Plan during service in the uniformed services by submitting the applicable forms to the Participating Employer, as applicable.

Section 8.3. Election of USERRA Continuation Coverage.

(a) The Eligible Employee may elect to continue coverage described in Section 8.2 by reason of service in the Uniformed Services for himself and his covered dependents. (Dependents and/or Domestic Partners do not have an independent right to elect USERRA continuation coverage.) The election period for continued coverage will begin on the date the Eligible Employee gives the Employer advanced notice that he or she is required to report for service in the Uniformed Services (whether such service is voluntary or involuntary) and will end sixty (60) days after the date the Eligible Employee would lose coverage.

(b) If the Eligible Employee is unable to give advance notice of service in the Uniformed Services, the Eligible Employee may still be able to elect continuation coverage under this Article if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period will begin on the date the Eligible Employee leaves for service in the Uniformed Services and will end on the earlier of: (i) the last day of the twenty-four (24) month period beginning on the date on which the Eligible Employee's absence for service in the Uniformed Services begins or (ii) the date on which the Eligible Employee fails to return from service in the Uniformed Services or apply for a position of employment as provided under 20 C.F.R. §§ 102.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 C.F.R. § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Employer is unavailable or the Eligible Employee is required to report for service in the Uniformed Services in an extremely short period of time.

(c) The Plan election of USERRA continuation coverage must be made on a form provided by the Plan Administrator or its designee and made within the sixty (60) day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator or its designee. If timely elected pursuant to this Section, coverage will be reinstated as of the date the Eligible Employee lost coverage due to absence for service in the Uniformed Services and will last for the period set forth in Section 8.2; provided that the Eligible Employee pays all unpaid costs for the coverage pursuant to Section 8.4.

Section 8.4. Cost of USERRA Continuation Coverage. If an Eligible Employee and/or the eligible covered dependent(s) of such Eligible Employee elect continuation coverage pursuant to Section 8.1, such Eligible Employee and/or eligible covered dependent(s) will be required to pay one hundred two percent (102%) of the full premium cost for such coverage (which represents the Participating Employer's share and the Eligible Employee's share, plus a 2% administrative fee); provided, however, if such Eligible Employee's service in the Uniformed Services is for a period of fewer than thirty-one (31) days, such person(s) will not be required to pay more for such coverage than is otherwise required for eligible persons.

Premiums are due on the first day of each month for which continuation coverage is desired. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, will only be considered to be timely if made within thirty (30) days after the date due. A premium must also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within forty-five (45) days after the date of election. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

Section 8.5. Coordination with COBRA. An Eligible Employee who is absent from work by reason of service in the Uniformed Services may be eligible for continuation coverage under Article IV. The continuation coverage provided in this Article will not limit or otherwise interfere with those continuation coverage rights detailed in Article IV;

provided, however, any continuation coverage provided under this Article will run concurrently with any continuation coverage available under Article IV.

Section 8.6. USERRA Continuation Health Benefits Provided. The continuation coverage provided to an Eligible Employee serving in the Uniformed Services who elects continued coverage (and his covered dependents) will be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage who are active. If coverage is modified under the group health coverage for any group of similarly situated beneficiaries, such coverage will also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the group health plan coverage under the applicable Benefit Program provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the group health plan coverage under the applicable Benefit Program, or to add or eliminate coverage of family members, the group health plan coverage under the applicable Benefit Program will provide the same opportunity to individuals who have elected USERRA continuation coverage.

Section 8.7. Waiting Period and Exclusions Upon Reemployment. Notwithstanding any other provision herein, an Eligible Employee and his or her eligible covered dependents whose benefit coverage is terminated by reason of service in the Uniformed Services will not be subject to any exclusion or waiting period upon reinstatement of such coverage under the group health coverage under the applicable Benefit Program following service in the Uniformed Services; provided, however, the above will not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of service in the Uniformed Services.

Section 8.8. Reinstatement of Coverage Upon Reemployment. The Employer will promptly reinstate the group health plan coverage under the applicable Benefit Program at reemployment upon request, consistent with the terms of the applicable Benefit Program.

Section 8.9. Rights, Benefits, and Obligations of Employees Absent from Employment by Reason of Service in the Uniformed Services. An Eligible Employee who is absent from employment with the Participating Employer by reason of service in the Uniformed Services will be considered on furlough or leave of absence while performing such service and will be entitled to such other rights and benefits as are generally provided by the Employer to Employees having similar status and pay who are on furlough or leave of absence; provided, however, an Eligible Employee who knowingly provides written notice of intent not to return to employment with the Employer will cease to be entitled to such rights and benefits. Furthermore, an Eligible Employee who is absent from employment with the Employer by reason of service in the Uniformed Services will be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of service in the Uniformed Services.

ARTICLE IX
FUNDING POLICY AND CONTRIBUTIONS TO THE PLAN

The Company will be responsible for establishing and carrying out the funding policy of the Plan for the provisions of benefits consistent with the objectives of the Plan. Certain uninsured Benefit Programs adopted by the Company may be paid from the general assets of the Employer or through a trust. Contributions to provide fully insured or self-insured benefits under the Plan will be paid to the appropriate insurance company or benefit provider pursuant to the applicable insurance policy or benefit contract of the Benefit Program. All Benefit Program contributions may consist of Employer contributions or Eligible Employee contributions, as applicable. The Company or Employer will determine the amount, if any, of required contributions to be made by each Eligible Employee with respect to each Benefit Program. Required Eligible Employee contributions for Benefit Programs will be communicated to Eligible Employees.

Eligible Employee contributions will be treated as Company contributions consistent with Article X.

ARTICLE X
PRE-TAX PREMIUM ELECTIONS

Section 10.1. Elections When First Eligible. An Eligible Employee who first becomes eligible to make contributions under this Article X during a Plan Year may elect to commence participation in one or more Benefit Program offered on a pre-tax basis under this Article on the first day of the pay period after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the pay period in which participation shall commence. The provisions of this Article are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the underlying Benefit Programs.

Section 10.2. Elections During Open Enrollment Period. During each open enrollment period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Eligible Employee. The Election Form/Salary Reduction Agreement shall enable the Eligible Employee to elect to participate in the various Benefit Programs of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for those Benefit Programs elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the open enrollment period, and it shall become effective on the first day of the next Plan Year.

Section 10.3. Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement. If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 10.1 and 10.2, then the Eligible Employee may not elect any Benefit Programs on a pre-tax basis under this Article: (a) until the next open enrollment period; or (b) until an event occurs that would justify a mid-year election change, as described under Sections 10.9 and 10.10.

Section 10.4. Irrevocability of Elections. Unless an exception applies (as described in Sections 10.9 and 10.10, a Participant's election under the Plan is irrevocable for the duration of the period of coverage to which it relates.

Section 10.5. Using Salary Reductions to Make Contributions.

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefit Programs elected, an amount equal to: (1) the annual Contributions for such Benefit Programs, divided by the number of pay periods in the period of coverage; (2) an amount otherwise agreed upon between the Company and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (*i.e.*, in the event of shortage in reducible Compensation, amounts withheld and the Benefit Programs to which Salary Reductions are applied may fluctuate).

(b) *Considered Company Contributions for Certain Purposes.* Salary Reductions are applied by the Company to pay for the Participant's share of the Contributions for the Benefit Programs, for the purposes of this Article and the Code, are considered to be Company contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Company shall, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

Section 10.6. Benefits. The Benefit Programs that are offered under this Article on a pre-tax basis are (1) medical plan benefits, (2) dental plan benefits, and (3) vision benefits. An Eligible Employee can: (a) elect these Benefit Programs by electing to pay for his or her share of the Contributions for such coverage on a pre-tax Salary Reduction basis; or (b) elect no benefits under such plans. Unless an exception applies (as described above), such election is irrevocable for the duration of the period of coverage to which it relates.

Section 10.7. Irrevocability of Elections. Except as described in this Article, a Participant's election under this Article is irrevocable for the duration of the period of coverage to which it relates.

Section 10.8. Procedure for Making New Election, if Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible or during the open enrollment period declined to be a Participant) may make a new election within thirty (30) days of the occurrence of an event described in Sections 10.9 and 10.10, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period. Notwithstanding the foregoing, a Change in Status (*e.g.*, a divorce) that results in a beneficiary becoming ineligible for coverage under the applicable Benefit Program shall automatically result in a corresponding

election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* These elections shall be effective for the balance of the period of coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 10.10(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (*i.e.*, election changes shall become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Program commences later).

Section 10.9. Change in Status Defined. A Participant may make a new election upon the occurrence of certain events, including a Change in Status, for the applicable Benefit Program. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependent/Children.* Events that change a Participant's number of children or dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her spouse, children, or dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her spouse, children or dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a dependent to satisfy or cease to satisfy the dependent eligibility requirements for a particular benefit; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her spouse, children, or dependents; or

(f) *Other.* Such other circumstances as specifically deemed a Change in Status Event by the Internal Revenue Service in its regulations.

Section 10.10. Events Permitting Exception to Irrevocability Rule for All Benefits. A Participant may change an election, as described below, upon the occurrence of the stated events for the applicable Benefit Program of this Plan:

(a) *Open Enrollment Period.* A Participant may change an election during the open enrollment period.

(b) *Termination of Employment.* A Participant's Salary Reduction Election shall terminate upon termination of employment, as applicable.

(c) *Leaves of Absence.* A Participant may change a Salary Reduction Election upon FMLA leave and upon non-FMLA leave.

(d) *Change in Status.* A Participant may change his or her actual or deemed Salary Reduction Election upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Company or a plan of the spouse's, child's, or dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Company or a plan of the spouse's, child's, or dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (*i.e.*, a spouse, children and/or dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(i) *Loss of Spouse, Child, or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a spouse or a dependent, or a child or a dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for: (a) the spouse involved in the divorce, annulment, or legal separation; (b) the deceased spouse or dependent; or (c) the child or dependent who ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her spouse, child, or dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Company's plan (and the Participant remains a Participant), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(ii) *Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which a Participant or his or her spouse, child, or dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's spouse, child, or dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the spouse's, child's, or dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained, or shall obtain, coverage under the spouse's, child's, or dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights.* If a Participant or his or her spouse, child, or dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right shall arise in the following circumstances:

(i) a Participant or his or her spouse, child, or dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (a) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (b) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

(ii) new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible dependents, as a result of the acquisition of a new spouse, child, or dependent, shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days). For purposes of this subsection (e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which

an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

An Employee or dependent who is eligible to participate in the medical plan, but who is not enrolled in the medical plan, shall be permitted to enroll in this Article if:

(i) The Employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act ("Act") or under a State child health plan under Title XXI of such Act and coverage of the Employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage under the medical plan no later than sixty (60) days after the date of termination of such coverage; or

(ii) The Employee or dependent becomes eligible for assistance, with respect to coverage under the medical plan under such Medicaid plan or state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests coverage under the medical plan no later than sixty (60) days after the date the Employee or dependent is determined to be eligible for such assistance.

(f) *Certain Judgments, Decrees and Orders.* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a dependent of the Participant), then a Participant may: (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's spouse or former spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid.* If a Participant or his or her spouse, child, or dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (*i.e.*, becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her spouse, child, or dependent, who has been entitled to Medicare or Medicaid, loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost.* For purposes of this subsection (h), "similar coverage" means coverage for the same category of benefits for the same individuals (*e.g.,* family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition: (1) an HMO and a PPO are considered to be similar coverage; and (2) coverage by another employer, such as a

spouse's, child's, or dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(i) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Program, and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, shall automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(j) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Program significantly increases during a period of coverage, then the Participant may: (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive, on a prospective basis, coverage under another Benefit Program that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Program available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(k) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Program significantly decreases during a period of coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Program may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Program may change their election on a prospective basis to elect the Benefit Program that has decreased in cost; or (c) Employees who are otherwise eligible may elect the Benefit Program that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Program. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(l) *Change in Coverage.* The definition of "similar coverage" under subsection (h) applies also to this subsection (l).

(i) *Significant Curtailment.* If coverage is "significantly curtailed", Participants may elect coverage under another Benefit Program option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage", then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, shall decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(ii) *Significant Curtailment without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Program option (or the Participant's spouse's or dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a period of coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit option that provides similar coverage (such as the HMO). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(iii) *Significant Curtailment with a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Program option for coverage under this Plan (or the Participant's spouse's, child's, or dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a period of coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Program option that provides similar coverage or drop coverage if no other Benefit Program option providing similar coverage is offered by the Company.

(iv) *Definition of Loss of Coverage.* For purposes of this subsection (i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Program option, an HMO ceasing to be available where the Participant or his or her spouse, child or dependent resides, or a Participant or his or her spouse, child, or dependent losing all coverage under the Benefit option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Program option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the plan's network);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her spouse, child or dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(v) *Addition or Significant Improvement of a Benefit Program Option.* If, during a period of coverage, the Plan adds a new Benefit Program option or significantly improves an existing Benefit Program option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a

Benefit Program option other than the newly added or significantly improved Benefit Program option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Program option; and (b) Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Program option on a prospective basis, subject to the terms and limitations of the Benefit Program option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall decide whether there has been an addition of, or a significant improvement in, a Benefit Program option in accordance with prevailing IRS guidance.

(vi) *Loss of Coverage under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her spouse, child or dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Program option(s).

(vii) *Change in Coverage under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Company or a plan of the spouse's, child's or dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a period of coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

Section 10.11. Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a period of coverage if the Plan Administrator determines that such action is necessary or advisable in order to: (a) satisfy any of the Code's nondiscrimination requirements applicable to a cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Article; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Company's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator shall reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected

the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XI
ADMINISTRATION OF THE PLAN
AND DISCRETIONARY AUTHORITY

Section 11.1. Plan Administrator. The Company will be the Plan Administrator of the Plan within the meaning of the Act; however, the Company, acting through its Board of Directors or an authorized officer of the Company, may from time to time designate a person, committee or organization to perform certain administrative functions of the Plan Administrator for any Benefit Program and/or for the Plan. Any such individual, committee or organization will perform the delegated functions until removed by the Company, which removal may be without cause and without advance notice. Except as otherwise specifically provided in the Plan or in any Benefit Program, the Plan Administrator will be the named fiduciary of the Plan. The Plan Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator or its designee will have the full discretion, power, and duty to take all action necessary or proper to carry out the duties required under the Act. The Plan Administrator or its designee is authorized to accept service of legal process for the Plan.

Section 11.2. Claims Administrator. The Company may appoint or remove a Claims Administrator with respect to any or all of the benefits under the Plan.

Section 11.3. Discretionary Authority of Plan Administrator. Except as may be otherwise specifically provided in the Plan or in any Benefit Programs, the Plan Administrator or its designee will have full, discretionary authority to control and manage the operation and administration of the Plan and to enable it to carry out its duties under the Plan, including, but not limited to, the authority to determine eligibility under the Plan and to construe the terms of the Plan and to determine all questions of fact or law arising hereunder. The Plan Administrator or its designee will have all power necessary or convenient to enable the Plan Administrator to exercise such authority and will be the named fiduciary of the Plan. Subject to Article XII, all such determinations and interpretations will be final, conclusive, and binding on all persons affected thereby. The Plan Administrator or its designee will have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient and the Plan Administrator or its designee will be the sole and final judge of such expediency. Except as may be provided under Section 12.3(h), (i) and (j) below with respect to the External Review process, benefits under the Plan will be paid only if the Plan Administrator and/or its designee decide in its discretion that the Eligible Employee is entitled to such benefits.

ARTICLE XII
CLAIMS PROCEDURE AND COORDINATION OF CLAIMS PROCEDURES

Section 12.1. Coordination of Claims Procedures. The following procedures will apply only (1) to the extent that the Benefit Program has no claims provisions and is subject to the requirements under Section 503 of the Act, and (2) to the extent that the claims procedures of the Benefit Program do not comply with the requirements under Section 503 of the Act (or PPACA) but such compliance is legally required. Subject to the preceding sentence, Section 12.2 will apply to claims for long-term disability benefits subject to the requirements of Section 503 of the Act, Section 12.3 will apply to health claims, Section 12.4 will apply to claims for all other welfare plans subject to the requirements of Section 503 of the Act, and Section 12.5 will apply to all claims for benefits, unless otherwise noted. All notifications by any Claims Administrator to a claimant for claim review, denial, approval and appeal may be done in writing or electronically, unless otherwise designated.

Section 12.2. Claims for Long-Term Disability Benefits.

(a) Initial Claim for Long-Term Disability Benefits. Any claim to receive long-term disability benefits under the appropriate Benefit Program under the Plan must be filed with the Claims Administrator within the designated time period on the designated form, and will be deemed filed upon receipt. As part of the claim, the Eligible Employee must submit any required physician statement on the appropriate form establishing that the Eligible Employee is disabled (as defined under the applicable disability Benefit Program) and indicate the injury or illness causing the disability. If the Claims Administrator disagrees as to an Eligible Employee's initial or continuing disability, the terms of the applicable disability Benefit Program will be followed in resolving any such dispute. Upon a finding of a disability, the Eligible Employee will be deemed disabled as of the commencement of such disability.

(b) Initial Review of Long-Term Disability Benefit Claim. When a claim for long-term disability benefits has been properly filed, the claimant will be notified of the approval or the denial within forty-five (45) days after the receipt of such claim. If special circumstances require an extension of time for processing the claim, the forty-five (45) day period may be extended for up to two (2) different extension periods, each consisting of thirty (30) additional days. Written notice of the extension(s) will be furnished to the claimant prior to the expiration of the initial forty-five (45) day period and the first thirty (30) day extension period, as applicable, and will (i) specify the reasons for the extension(s) and when a final decision will be reached, and (ii) explain the standards for payment, the unresolved issues that prevent a decision, and the information needed to resolve those issues. The claimant will have forty-five (45) days to provide any specified information to the Claims Administrator.

(c) Initial Denial of Long-Term Disability Benefit Claims. If any claim for long-term disability benefits is partially or wholly denied, the claimant will be given notice which will contain: (i) the specific reasons for the denial; (ii) references to specific disability Benefit Program provisions on which the denial is based; (iii) a description of any additional material or information needed and why such material or information is necessary; (iv) a

description of the review procedures and time limits; (v) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request; (vi) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; (vii) a description of the disability review procedures and time limits (including a statement of your right to bring a civil action under ERISA Section 502(a) and a description of any contractual limitation periods that applies to bringing an action including the date the contractual limitation period expires for the claim; and (viii) a discussion of the decision with an explanation for disagreeing with (a) views of the claimant's health care or vocational professionals or the Social Security Administration (as applicable), (b) views of the medical or vocational professional whose advice was obtained (whether or not relied upon), and (c) any Social Security Administration disability determination.

(d) Appeal of Long-Term Disability Benefit Claim Denial. A claimant may appeal the denial of a claim for long-term disability benefits by filing a written claim appeal with the Claims Administrator within one hundred eighty (180) days after the claimant receives notice of the denial, and will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Administrator will be the final decision of the applicable Benefit Program, and will be final, conclusive, and binding on all persons.

(e) Denial of Long-Term Disability Benefit Appeal. The claimant will receive notice of the Claims Administrator's decision on appeal within forty-five (45) days after receipt of the claimant's appeal request, unless special circumstances require an extension of time for processing the appeal and the Claims Administrator notifies the claimant (i) of the extension and (ii) when a final decision will be reached (which will not be later than ninety (90) days after receipt of such appeal).

If the long-term disability claim is denied on appeal, the claimant will be given notice containing a statement that the claimant is entitled to receive, upon request, all documents relevant to the claim and access to the entire claim file free of charge, as well as items (i), (ii), (v), (vi), (vii), and (viii) under subsection (c) above. Whether a document, record, or other information is relevant to a claim for benefits will be determined by Department of Labor Regulation Section 2560.503-1(m)(8). Finally, a decision on review will be final, conclusive, and binding on all persons.

(f) Additional Claims Processes for Disability Claims. All disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions, such as claims adjudicators and medical/vocational experts (i.e., not based on the likelihood that the individual will support the denial of benefits).

In addition, the claimant will be given the opportunity to submit issues and written comments to the Plan Administrator, as well as to review and receive, without charge, all relevant (as defined in applicable ERISA regulations) documents, records and other information relating to the claim. The Plan Administrator will take into account all

comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination. The claimant will be given a fair opportunity to respond to new or additional evidence or rationales before they become a basis for denials and filing an appeal. The claim will be reviewed by an individual or committee who did not make the initial determination that is subject of the appeal, nor by a subordinate of the individual who made the determination, and the review will be made without deference to the initial adverse benefit determination. If the initial adverse benefit determination was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involving the medical judgment. The health care professional who is consulted on appeal will not be the same individual who was consulted during the initial determination or the subordinate of such individual.

Section 12.3. Claims for Health Benefits.

(a) Initial Claim for Health Benefits. Any claim to receive health benefits under the appropriate Benefit Program under the Plan must be filed with the Claims Administrator within the designated time period on the designated form, and will be deemed filed upon receipt. If a claimant fails to follow the claims procedures outlined herein for filing an Urgent Care Claim or a Pre-Service Claim, the claimant will be notified orally (unless the claimant requests written notice) of the proper procedures to follow, not later than twenty-four (24) hours for Urgent Care Claims and five (5) days for Pre-Service Claims. This special timing rule applies only to Urgent Care Claims and Pre-Service Claims that: (i) are received by the person or unit customarily responsible for handling benefit matters; and (ii) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Eligible Employee must submit any required physician statements on the appropriate form (as required under the applicable health Benefit Program). If the Claims Administrator disagrees with the physician statement, the terms of the applicable health Benefit Program will be followed in resolving any such dispute.

(b) Initial Review of Health Benefit Claims. When a claim for health benefits has been properly filed, the claimant will be notified of the approval or Denial within the time periods set forth in the chart under subsection (g) below.

(c) Initial Denial of Health Benefit Claims. If any claim for health benefits is partially or wholly Denied, the claimant will be given notice which will contain:

(1) the specific reasons for the Denial;

(2) references to applicable Benefit Program provisions upon which the Denial is based;

(3) a description of any additional material or information needed and why such material or information is necessary;

(4) a description of the review procedures and time limits, including information regarding how to initiate an Appeal, information on the External Review process (with respect to Medical Benefits and/or Prescription Drug Benefits), and a statement of the claimant's right to bring civil action under Section 502(a) of the Act following a Denial on Appeal;

(5) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(6) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(7) for Urgent Care Claims, a description of the expedited review process applicable to such claims; and

(8) for Denials of Medical Benefits and/or Prescription Drug Benefits, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the Denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in the Denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review processes.

For Urgent Care Claims, the information in the notice may be provided orally if the claimant is given notification within three (3) days after the oral notification.

(d) Appeal(s) of Health Benefit Claim Denial. A claimant may Appeal the Denial of a health claim by filing a written claim Appeal(s) with the Claims Administrator within the time period set forth in the chart in subsection (g) below, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Administrator will be the final decision of the applicable Benefit Program, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a claimant may make a request for an expedited appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

(e) Denial of Health Benefit Appeal(s). The claimant will receive notice of the Claims Administrator's decision on Appeal(s) within the time periods set forth in the chart in subsection (g) below. If the claim for Medical Benefits and/or Prescription Drug Benefits is Denied on Appeal, the notice will serve as the Final Denial.

(1) With respect to claims for Medical Benefits and/or Prescription Drug Benefits, the Claims Administrator will provide the claimant with the

following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Denial is required under paragraph (2) below, such that the claimant has a reasonable opportunity to respond prior to that date: (A) any new or additional evidence considered, relied upon, or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with the claim, and (B) any new or additional rationale that forms the basis of the Claims Administrator's Final Denial, if any.

(2) In addition, if the health claim is denied on Appeal (including a Final Denial), the claimant will be given notice with a statement that the claimant is entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

(i) the specific reasons for the Denial;

(ii) references to applicable Benefit Program provisions upon which the Denial is based;

(iii) a description of the review procedures and time limits, including information regarding how to initiate an Appeal, information on the External Review process (with respect to Medical Benefits and/or Prescription Drug Benefits), and a statement of the claimant's right to bring civil action under Section 502(a) of the Act following a Denial on Appeal;

(iv) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request.

(v) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(vi) for Denials of Medical Benefits and/or Prescription Drug Benefits, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the Denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in the Denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review process; and

(vii) for Denials of Medical Benefits and/or Prescription Drug Benefits, if the Denial is a Final Denial, a discussion of the decision. Except as provided in subsections (h) through (j) below with respect to claims for

Medical Benefits and/or Prescription Drug Benefits, the decision on review will be final, conclusive, and binding on all persons.

(f) Ongoing Treatments. If the Claims Administrator has approved an ongoing course of treatment to be provided to a claimant over a certain period of time or for a certain number of treatments, any reduction or termination of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The claimant will be notified of the Denial, in accordance with subsection (e), before the reduction or termination occurs to allow the claimant a reasonable time to file an appeal and obtain a determination on the appeal. With respect to Appeals for Medical Benefits and/or Prescription Drug Benefits, coverage for the ongoing course of treatment that is the subject of the Appeal will continue pending the outcome of such Appeal.

For an Urgent Care Claim, any request by a claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than twenty-four (24) hours after receipt of the Urgent Care Claim, provided the claim is filed at least twenty-four (24) hours before the treatment expires.

(g) Chart of Time Limits for Health Benefit Claims.

MAXIMUM TIME LIMITS FOR:			
TYPE OF CLAIM	**URGENT CARE CLAIMS**	**PRE-SERVICE CLAIMS**	**POST-SERVICE CLAIMS**
Claims Administrator to decide initial claim (if no additional information is needed) (whether adverse or not).	No later than 72 hours after receipt of claim by the Claims Administrator.	No later than 15 days after receipt of claim by the Claims Administrator.	No later than 30 days after receipt of claim by the Claims Administrator.
Extension of time by Plan for determining initial claim.	None	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies claimant before end of initial 15-day time period of such extension and the date Claims Administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. Note: Claims Administrator	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies claimant before end of initial 30-day time period of such extension and the date Claims Administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. Note: Claims Administrator

MAXIMUM TIME LIMITS FOR:			
TYPE OF CLAIM	**URGENT CARE CLAIMS**	**PRE-SERVICE CLAIMS**	**POST-SERVICE CLAIMS**
		may or may not allow extension due to claimant's failure to provide needed information.	may or may not allow extension due to claimant's failure to provide needed information.
Claims Administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant.	No later than 24 hours after receipt of incomplete claim by Claims Administrator.	N/A	N/A
Claims Administrator to notify claimant of claimant's failure to follow proper procedures.	No later than 24 hours after receipt of improper claim by Claims Administrator.	No later than 5 days after receipt of improper claim by Claims Administrator.	N/A
Claimant to then provide needed information (if extension allowed by Plan).	Not less than 48 hours after receipt of notice from Claims Administrator.	At least 45 days after receipt of notice from Claims Administrator. Note: Claims Administrator may or may not request needed information from claimant.	At least 45 days after receipt of notice from Claims Administrator. Note: Claims Administrator may or may not request needed information from claimant.
Claims Administrator to decide claim after requesting additional information and notifying claimant (if applicable).	No later than 48 hours after earlier of (i) Claims Administrator's receipt of additional information from claimant or (ii) end of time period given to claimant to provide additional information (48 hours).	No later than 15 days after earlier of (i) Claims Administrator's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days).	No later than 15 days after earlier of (i) Claims Administrator's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)
Claimant to file appeal(s).	180 days after receipt of denial by claimant. If second level of appeal applies – claimant not to have reasonable opportunity to pursue second appeal.	180 days after receipt of denial by claimant. If second level of appeal applies – claimant to have reasonable opportunity to pursue second appeal.	180 days after receipt of denial by claimant. If second level of appeal applies – claimant to have reasonable opportunity to pursue second appeal.
Claims Administrator to decide appeal(s).	All appeals (first and/or second levels,	One Level Appeal: 30 days after receipt of	One Level Appeal: 60 days after receipt of

MAXIMUM TIME LIMITS FOR:			
TYPE OF CLAIM	**URGENT CARE CLAIMS**	**PRE-SERVICE CLAIMS**	**POST-SERVICE CLAIMS**
	as applicable) must be decided within 72 hours after receipt of appeal by Claims Administrator.	appeal by Claims Administrator. Two Level Appeal: First level – 15 days after receipt of first level appeal request by Claims Administrator. Second level – 15 days after receipt of second level appeal request by Claims Administrator.	appeal by Claims Administrator. Two Level Appeal: First level – 30 days after receipt of first level appeal request by Claims Administrator. Second level – 30 days after receipt of second level appeal request by Claims Administrator.

(h) Application and Scope of Federal External Review Process for Medical Benefits and/or Prescription Drug Benefit Claims.

(1) Subject to subsection (2) below, upon receipt of a Final Denial (including a deemed Final Denial) with respect to Medical Benefits and/or Prescription Drug Benefits, the claimant may apply for External Review as provided in subsection (i) or (j) below, as applicable. Upon receipt of a Denial with respect to Medical Benefits and/or Prescription Drug Benefits that is not a Final Denial, the claimant may only apply for External Review as provided under subsection (j)(1)(A) regarding expedited External Review for Urgent Care Claims.

(2) A claimant may request External Review for any Final Denial or eligible Denial with respect to Medical Benefits and/or Prescription Drug Benefits, except that a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility based under the terms of the Plan is not eligible for External Review.

(i) Standard External Review Process for Claims for Medical Benefits and Prescription Drug Benefits.

(1) Timing of Request for External Review. The claimant must file a request for External Review of a Medical Benefit and/or Prescription Drug Benefit claim with the Claims Administrator no later than the date which is four (4) months following the date of receipt of a notice of Final Denial. If there is no corresponding date four (4) months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a Final Denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, or Federal

holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(2) Preliminary Review. The Claims Administrator will complete a preliminary review of the request for External Review within five (5) business days to determine whether (A) the claimant is or was covered under the applicable Benefit Program at the time the covered service was requested or provided, as applicable; (B) the Final Denial does not relate to the claimant's failure to meet the applicable Benefit Program eligibility requirements; (C) the claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims and Appeals process under Section 12.3(d); and (D) the claimant has provided all information and forms required to process an External Review. The Claims Administrator will issue a notification to the claimant within one (1) business day of completing the preliminary review. If the request is complete, but ineligible for External Review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Claimant will be allowed to perfect the request for External Review by the later of the four (4) month filing period described in paragraph (1) above, or within the 48-hour period following the receipt of the notification.

(3) Referral to Independent Review Organization (IRO). The Claims Administrator will assign an IRO to the claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the request for External Review:

(i) Timely notify the claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the claimant may submit in writing to the IRO, within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

(ii) Review all documents and any information considered in making a Final Denial received by the Claims Administrator. The Claims Administrator will provide the IRO with such documents and information within five (5) business days after the date of assignment of the IRO. Failure by the Claims Administrator to timely provide the documents and information will not delay the conduct of the External Review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Final Denial. In such case, the IRO will notify the claimant and the Claims Administrator of its decision within one (1) business day.

(iii) Forward any information submitted by the claimant to the Claims Administrator within one (1) business day of receipt. Upon receipt

of any such information, the Claims Administrator may reconsider its Final Denial that is the subject of the External Review. Reconsideration by the Claims Administrator must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Claims Administrator decides to reverse its Final Denial and provide coverage or payment. In such case, the Claims Administrator must provide written notice of its decision to the claimant and IRO within one (1) business day, and the IRO will then terminate the External Review.

(iv) Review all information and documents timely received under a *de nova* standard. The IRO will not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and Appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, will further consider the following in reaching a decision: (a) the claimant's medical records; (b) the attending health care professionals recommendation; (c) reports from appropriate health care professionals and other documents submitted by the Claims Administrator, the claimant, or the claimant's physician; (d) the terms of the applicable Benefit Program to ensure that the IRO's decisions is not contrary to the terms of the Benefit Program, unless the terms are inconsistent with applicable law; (e) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (f) any applicable clinical review criteria developed and used by the Benefit Program, unless the criteria are inconsistent with the terms of the Benefit Program or with applicable law; and (g) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

(4) Notice of Final External Review Decision. The IRO will provide written notice of Final External Review Decision within forty-five (45) days after the IRO receives the request for External Review. Such notice will be delivered to the claimant and the Claims Administrator and will contain the following: (A) a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial); (B) the date the IRO received the assignment to conduct External Review and the date of the Final External Review Decision; (C) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision; (D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Benefit

Program or the claimant; (F) a statement that judicial review may be available to the claimant; and (G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

(5) Reversal of Plan's Decision. If the Final Denial of the Claims Administrator is reversed by the Final External Review Decision, the applicable Benefit Program will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

(6) Maintenance of Records. The IROs will maintain records of all claims and notices associated with an External Review for six (6) years. An IRO must make such records available for examination by the claimant, the Claims Administrator, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(j) Expedited External Review Process for Claims for Medical Benefits or Prescription Drug Benefits.

(1) Application of Expedited External Review. The Plan will allow the claimant to make a request for expedited External Review at the time the claimant receives either:

(i) A Denial with respect to Medical Benefits and/or Prescription Drug Benefits, if the Denial involves a medical condition of the claimant for which the timeframe for completion of an internal Appeal of an Urgent Care Claim would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an Appeal of an Urgent Care Claim; or

(ii) A Final Denial with respect to Medical Benefits and/or Prescription Drug Benefits, if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(2) Preliminary Review. Immediately upon receipt of a request for expedited External Review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in paragraph (1) above. The Claims Administrator will immediately send a notice that meets the requirements set forth in subsection (i)(2) above for standard External Review of the claimant for its eligibility determination.

(3) Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth in subsection (i)(3) above for standard External Review. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described under subsection (i)(3)(D) above under the procedures for standard External Review. In reaching a decision, the assigned IRO will review the claim *de novo* and is not bound by any decisions or conclusions reached during the Claims Administrator's internal claims and Appeals process.

(4) Notice of Final External Review Decision. The IRO will provide notice of Final External Review Decision, in accordance with the requirements set forth in subsection (i)(4) above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within forty-eight (48) hours after the date of providing such notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Claims Administrator.

(k) Form and Manner of Notices Pertaining to Medical Benefits and/or Prescription Drug Benefits Claims. Notices provided pursuant to this Section 12.3 with respect to internal claims and Appeals and External Review with respect to Medical Benefits and/or Prescription Drug Benefits will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, if the lesser of 500 Participants, or 10 percent or more of all Participants are literate only in the same non-English language, the Claims Administrator will provide notices under this Article in that non-English language upon request. In such case, the Claims Administrator will also: (1) include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language; (2) once such a request has been made by the claimant, provide all subsequent notices to the claimant in the non-English language; and (3) to the extent the Claims Administrator maintains a customer assistance process (such as a telephone hotline) that answers questions and provides assistance with filing claims and Appeals, the Claims Administrator will provide such assistance in the non-English language.

Section 12.4. Claims for All Other Welfare Benefits Subject to the Act. This Section will apply to all claims for welfare benefits under the Plan not governed by Section 12.1 through 12.3.

(a) Initial Claim for Other Welfare Benefits. Any claim to receive welfare benefits (other than claims for (i) long-term disability benefits, or (ii) health benefits) under the appropriate Benefit Program under the Plan, must be filed with the Claims Administrator within the designated time period on the designated form, and will be deemed filed upon receipt.

(b) Initial Review of Other Welfare Benefit. A claim for welfare benefits (other than claims for (i) long-term disability benefits, or (ii) health benefits) will be evaluated and the claimant will be notified of the Approval or Denial within ninety (90) days after the claim is received, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be furnished to the claimant prior to the termination of the initial ninety (90) day period specifying the circumstances requiring an extension and when a final decision will be reached (which will be no later than one hundred eighty (180) days after the claim was filed).

(c) Initial Denial of Other Welfare Benefits. If any claim for welfare benefits (other than a claim for (i) long-term disability benefits, or (ii) health benefits) is partially or wholly denied, the claimant will be given notice containing items (i)-(iv) under 12.3(c).

(d) Appeal of Other Welfare Benefits Claim Denial. A claimant may appeal the denial of a claim for welfare benefits (other than a claim for (i) long-term disability benefits, or (ii) health benefits) by filing a written appeal request with the Claims Administrator within sixty (60) days after the claimant receives notification of the denial, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Administrator will be the final decision of the applicable Benefit Program, and will be final, conclusive, and binding on all persons.

(e) Denial of Other Welfare Benefit Appeals. The claimant will receive notice of the Claims Administrator's decision on appeal within sixty (60) days after receipt of the claimant's appeal request, unless special circumstances require an extension of time to process the appeal and the Claims Administrator notifies the claimant (i) of the extension and (ii) when a final decision will be reached (which will not be later than one hundred twenty (120) days after receipt of such appeal).

If the claim for welfare benefits (other than a claim for (i) long-term disability benefits or (ii) health benefits) is denied on appeal, the claimant will be given notice containing a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim, as well as items (i) and (ii) under Section 12.3(c) above. A decision on review will be final, conclusive, and binding on all persons.

Section 12.5. For All Claims.

(a) Authorized Representative. The Plan and any underlying Benefit Program will not prevent an authorized representative of a claimant from acting on behalf of the claimant in pursuing a benefit claim or appeal, pursuant to reasonable procedures. In the case of an Urgent Care Claim, a health care professional with knowledge of a claimant's medical condition will be permitted to act as the authorized representative of the claimant.

(b) Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an appeal is required to be made will begin when a claim or appeal is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial Urgent Care Claims, Post-Service Claims, and long-term disability claims, if the time period for making the initial benefit determination is extended (in the Claims Administrator's discretion) because the claimant failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to the claimant until the earlier of (i) the date on which response from the claimant is received or (ii) the end of the time period given to the claimant to provide the additional information (at least forty-five (45) days).

Solely for purposes of appeals of long-term disability claims and other welfare claims (other than health claims), if the time period for making the determination on appeal is extended (in the Claims Administrator's discretion) because the claimant failed to submit information necessary to decide the appeal, the time period for making the determination on appeal will be suspended from the date notification of the extension is sent to the claimant until the earlier of (i) the date on which a response from the claimant is received or (ii) the end of the time period given to the claimant to provide the additional information (at least forty-five (45) days).

(c) Full and Fair Review. Upon request and free of charge, the claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted by the claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals for (i) long-term disability claims or (ii) health claims will be reviewed by the Claims Administrator who will be the named fiduciary of the Plan and who will be neither the individual nor subordinate of the individual who made the initial determination. Furthermore, such fiduciary will not give any weight to the initial determination. In the case of two levels of appeal, the second level reviewer will not afford deference to the first level reviewer, nor will the second level reviewer be the same individual or the subordinate of the first level reviewer. If any appeal is based, in whole or in part, on a medical judgment, the fiduciary will consult with an appropriate Health Care Professional who is neither the individual nor subordinate of the individual who was consulted in connection with any prior determination (including the initial determination, or the first level of appeal if a two level appeal process is used). The Claims Administrator will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

(d) Definitions. For purposes of this Section, the following terms will have the meanings set forth below whenever such terms are used in this Section:

(1) "Appeal" means review by the Claims Administrator of a Denial.

(2) "Denial" means a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to health benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be experimental or not medically necessary. With respect to Medical Benefits and/or Prescription Drug Benefits, it also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular Medical Benefit and/or Prescription Drug Benefit at that time.

(3) "External Review" means a review of a Denial (including a Final Denial) of Medical Benefits and/or Prescription Drug Benefits pursuant to the Federal External Review process described in subsection 12.3(h), (i), and (j) above.

(4) "Final Denial" means a Denial of Medical Benefits and/or Prescription Drug Benefits that has been upheld by the Claim Administrator at the completion of the internal Appeals process conducted on or after August 1, 2012 pursuant to Section 12.3(e), or a Denial of Medical Benefits and/or Prescription Drug Benefits with respect to which the internal Appeals process has been deemed exhausted as described under Section 12.5(d) (a "deemed Final Denial").

(5) "Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of External Review.

(6) "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(7) "Independent Review Organization" or "IRO" means an entity that conducts independent External Reviews of Denials and Final Denials.

(8) "Post-Service Claim" means any claim for a medical benefit that is not an Urgent Care Claim or a Pre-Service Claim.

(9) "Pre-Service Claim" means any claim for a medical benefit whereby the appropriate Benefit Program under the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.

(10) "Urgent Care Claim" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(e) Exhaustion of Remedies.

(1) If a claimant fails to file a request for review of a denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such claimant will have no right to review and no right to bring action, at law or in equity, in any court and the denial of the claim will become final and binding on all persons for all purposes.

(2) With respect to claims for Medical Benefits and/or Prescription Drug Benefits only: If the Claims Administrator fails to strictly adhere to all the requirements with respect to a claim under Section 12.3 and Section 12.5(a) through (c), the claimant is deemed to have exhausted the internal claims and Appeals process with respect to such claims. Accordingly, the claimant may initiate an External Review with respect to such claims as outlined in Section 12.3(h), (i), and (j) above. The claimant also is entitled to pursue any available remedies under Section 502(a) of the Act or State law, as applicable with respect to such claims.

ARTICLE XIII
SUBROGATION AND REIMBURSEMENT RIGHTS AND COORDINATION OF BENEFITS

Section 13.1. Right of Subrogation and Reimbursement. The following provisions will apply to the subrogation and reimbursement rights of this Plan, as well as any Benefit Program. For purposes of this Article, "Plan" will refer to the Plan and any underlying Benefit Program. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, an Eligible Employee under the Plan, for which a third party is allegedly responsible. This right applies to any amount reimbursed to the Participant, the Participant's Spouse, Domestic Partner, dependents, beneficiaries, any trust created for these individuals, estate, or legal counsel. Furthermore, the Plan is not required to trace the source of the funds from which reimbursement is made. The Plan will have a lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed therefrom.

Section 13.2. Funds To Which Subrogation and Reimbursement Rights Apply. The Plan's subrogation and reimbursement rights apply if the Participant receives, or has a right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan or legal entity that is legally obligated to make payments as a result of a judgment, settlement or otherwise, arising out of any act or omission of any third party (whether a third party or another Participant under the Plan), (i) who is allegedly wholly or partially liable for costs or expenses incurred by the Participant, in connection for which the Plan provided benefits to, or on behalf of, such Participant or (ii) whose act or omission allegedly caused injury or illness to the Participant, in connection for which the Plan provided benefits to, or on behalf of, such Participant.

Section 13.3. Agreement to Hold Recovery in Trust. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described in Section 12.2 as a result of settlement, judgment, or otherwise, that person will hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of its payments.

Section 13.4. Disclaimer of Make Whole Doctrine. The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the Participant has been "made whole." The Plan's right is a first priority lien. The Plan's right will continue until the Participant's obligations hereunder to the Plan are fully discharged, even though the Participant does not receive full compensation or recovery for his or her injuries, damages, loss, or debt. This right to subrogation pro tanto will exist in all cases.

Section 13.5. Disclaimer of Common Fund Doctrine. The Participant will be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the Participant will not reduce the amount of reimbursement due to the Plan.

Section 13.6. Obligations of the Eligible Employee. The Participant will furnish any and all information and assistance requested by the Plan Administrator. If requested, the Participant will execute and deliver to the Plan Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Participant will not discharge or release any party from any alleged obligation to the Participant or take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Plan Administrator.

Section 13.7. Plan's Right To Subrogation. If the Participant or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in Section 13.1 above or any other persons to obtain a judgment, settlement or other recovery, the Plan Administrator or its designee, upon giving thirty (30) days' written notice to the Participant, will have the right to take such action in the name of the Participant to recover that amount of benefits paid under the Plan; provided, however, that any action taken without the consent of the Participant will be without prejudice to such Participant.

Section 13.8. Enforcement of Plan's Right to Reimbursement. If a Participant fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over any and all funds received by the Participant, or as to which the Participant has the right to receive. The Plan, through the Plan Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Article, against any and all appropriate parties who may be in possession of the funds described herein.

Section 13.9. Withholding of Payments for Benefits. The Plan may withhold payment of benefits when a party other than the Participant or the Plan may be liable for expenses until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Participant or the Plan may be liable, the Plan will be subrogated to all rights of recovery of the Participant to the extent of payments by the Plan and will have the right to be reimbursed as set forth in this Article.

Section 13.10. Failure to Comply. If a Participant fails to comply with these requirements, the Participant will not be eligible to receive any benefits, services, or

payments under the Plan until there is compliance regardless of whether such benefits are related to the act or omission of such third party or other persons.

Section 13.11. Future Claims Excluded. If the Participant receives any sum of money described in Section 13.2 above, the Plan will have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications thereof, for which the Participant received such sum of money, and charges incurred for such services will be excluded.

Section 13.12. Discretionary Authority of Plan Administrator. The Plan, through the Plan Administrator, will have full discretionary authority to interpret the provisions of this Article, and to administer and pursue the Plan's subrogation and reimbursement rights. It will be within the discretionary authority of the Plan Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Plan Administrator is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

Section 13.13. Coordination of Benefits. If an individual claiming benefits under the Plan is covered under two or more plans (including the Benefit Programs under the Plan), benefits will be determined according to the coordination of benefits provision of the relevant Benefit Program document. If the Benefit Program contains no coordination of benefits provision, benefits will be determined as follows:

(a) A plan that has no coordination of benefits provision will always be deemed to have primary benefit payment responsibility.

(b) The plan covering the individual as an employee pays benefits first. The plan covering the individual as a dependent pays benefits second.

(c) If no plan is determined to have primary benefit payment responsibility under (b), then the plan that has covered the individual for the longest period has the primary responsibility.

(d) Except as otherwise provided in (e), the plan covering the parent of an eligible dependent pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The plan covering the parent of an eligible dependent pays second if the parent's birthday falls later in the year.

(e) In the event that the parents of the eligible dependent are divorced or separated, the following order of benefit determination applies:

(1) The plan covering the parent with custody of the eligible dependent pays benefits first.

(2) If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.

(3) If the parent with custody has remarried, then the plan covering the step-parent pays benefits second and the plan covering the parent without custody pays benefits third.

(4) If a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

(f) The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired pays benefits first. The plan covering that individual as a laid-off or retired employee (or as that individual's dependent) pays benefits second.

(g) The plan covering an individual as an employee (or as a dependent of the employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another plan, and such other plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any individual who is provided COBRA continuation under this Plan and who also is covered simultaneously under another plan as an employee (or as a dependent of an employee). In the event of conflicting coordination provisions between this Plan and any other plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

(h) Payments for benefits under the Plan will be reduced by any payments for the same benefits under Medicare. The reduction is the amount payable by Medicare whether or not the payment is actually made. Consequently, the payment for any benefits under the Plan will be determined by the person(s) or entity(ies) appointed by the Company to serve as the claims administrator for such Benefit Program., and then reduced by the amount payable by Medicare. Coordination of Plan benefits with Medicare will be determined in accordance with applicable federal regulations describing the order of benefit determination with respect to primary and secondary coverage.

ARTICLE XIV
AMENDMENT OR TERMINATION PROCEDURE

The following provisions will apply to the amendment and termination of this Plan. To the extent that any Benefit Program does not address amendment or termination of the Benefit Program, the following provisions will also apply to such Benefit Program. The Company, or its designee such as an authorized officer of the Company, will have the right, in its sole discretion, to amend or terminate the Plan or any underlying Benefit Program, as applicable, at any time and from time to time and to any extent that it may deem advisable. An amendment or termination of the Plan or underlying Benefit Program, as applicable, will be effective in accordance with the time limitations provided under the Act, or such later date as the Company, or its designee, may determine in connection herewith. To the extent allowed by the Act, any such amendment may be effective retroactively.

ARTICLE XV
ENTRY AND WITHDRAWAL OF EMPLOYERS

Section 15.1. Entry of Participating Employers. Any organization classified by the Company as a Participating Employer may become a party to the Plan and/or any Benefit Program hereunder on any effective date. Such organization will become a Participating Employer hereunder as of the date approved by the Company, and will be subject to the terms and provisions of the Plan as then in effect and thereafter amended. Such approval may be issued retroactively by the Company or its designee as of any effective date.

Section 15.2. Withdrawal from Plan. Any Participating Employer may withdraw from the Plan by delivering written notice to the Company or its designee.

ARTICLE XVI
MISCELLANEOUS PROVISIONS

The following provisions will apply only to the extent such provisions are not set forth in a similar provision of a Benefit Program provided under the Plan and/or are not inconsistent with the provisions thereof.

Section 16.1. Nonalienation. Except as otherwise required pursuant to a qualified medical child support order under Section 609 of the Act, no benefit under the Plan prior to actual receipt thereof by an Eligible Employee, dependent, or beneficiary will be subject to any debt, liability, contract, engagement, or tort of any Eligible Employee, dependent, or his or her beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntarily or involuntarily alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the Benefit Program.

Section 16.2. Headings. Any headings or subheadings in the Plan are inserted for convenience of reference only and will be ignored in the construction of any provisions of the Plan.

Section 16.3. Employment of Consultants. The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

Section 16.4. Designation of Fiduciaries. The Plan Administrator may designate another person or persons to carry out any fiduciary responsibility of the Plan Administrator under the Plan. The Plan Administrator will not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under the Act.

Section 16.5. Fiduciary Responsibilities. To the extent permitted under the Act, no fiduciary of the Plan will be liable for any act or omission in carrying out his or her responsibilities under the Plan.

Section 16.6. Allocation of Fiduciary Responsibilities. To the extent permitted under the Act, each fiduciary under the Plan will be responsible only for the specific duties assigned under the Plan and will not be directly or indirectly responsible for the duties assigned to another fiduciary.

Section 16.7. Limitation of Rights and Obligations. Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any Benefit Program, including any benefit contract or insurance policy, nor any act or omission under the Plan or resulting from the operation of the Plan will be construed:

(a) as conferring upon any Eligible Employee, dependent, beneficiary, or any other person any right or claim against the Company, an Employer, the Claims Administrator, or the Plan Administrator, except to the extent that such right or claim will be specifically expressed and provided in the Plan or provided under the Act;

(b) as creating any responsibility or liability of the Company, an Employer, the Plan Administrator, or the Claims Administrator for the validity or effect of the Plan;

(c) as a contract or agreement between the Company, an Employer and any Eligible Employee or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Eligible Employee or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of an Employer or any Eligible Employee or other person to continue or terminate the employment relationship at any time; or

(e) as giving any Eligible Employee or any other person the right to be retained in the service of an Employer or to interfere with the right of an Employer to discharge any Eligible Employee at any time.

Section 16.8. Notice. Any notice given under the Plan will be sufficient if given to the Plan Administrator, when addressed to its office; if given to the Claims Administrator, when addressed to its office; or if given to an Eligible Employee, when addressed to the Eligible Employee at his or her address as it appears in the records of the Plan Administrator or the Claims Administrator.

Section 16.9. Disclaimer of Liability. Nothing contained herein will confer upon an Eligible Employee any claim, right, or cause of action, either at law or at equity, against the Plan, the Plan Administrator, the Company, an Employer, or the Claims Administrator for the acts or omissions or any provider of services or supplies for any benefits provided under the Plan.

Section 16.10. Right of Recovery. If the Plan Administrator or the Claims Administrator makes any payment that, according to the terms of the Plan or any Benefit Program provided hereunder, should not have been made, the Plan Administrator or the Claims Administrator may recover that incorrect payment, whether or not it was made due to the Plan Administrator's or the Claims Administrator's own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to an Eligible Employee, then the Plan Administrator or the Claims

Administrator may deduct it when making future payments directly to that Eligible Employee.

Section 16.11. Legal Counsel. The Plan Administrator and/or its designee, may from time to time consult with counsel, who may be counsel for the Company, and will be fully protected in acting upon the advice of such counsel.

Section 16.12. Evidence of Action. All orders, requests, and instructions to the Plan Administrator or the Claims Administrator by the Company or by any duly authorized representative, will be in writing and the Plan Administrator and the Claims Administrator will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

Section 16.13. Audit. If an audit of the Plan is required under the Act for any Plan Year, the Plan Administrator will engage an independent qualified public accountant. Such audit will be conducted in accordance with the requirements of Section 103 of the Act.

Section 16.14. Bonding. Each fiduciary of the Plan, unless exempted under the Act, will be bonded in an amount not less than ten percent (10%) of the amounts of assets of the Plan handled by such fiduciary; provided, however, such bond will not be less than One Thousand Dollars ($1,000) and need not be for more than Five Hundred Thousand Dollars ($500,000). The expense of such bond will be paid from the assets of the Plan unless paid by the Company.

Section 16.15. Protective Clause. Neither the Company, an Employer, nor the Plan Administrator will be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider issued to the Company, or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Section 16.16. Receipt and Release. Any payments to any Eligible Employee will, to the extent thereof, be in full satisfaction of the claim of such Eligible Employee being paid thereby, and the Plan Administrator may condition payment thereof on the delivery by the Eligible Employee of the duly executed receipt and release in such form as may be determined by the Plan Administrator.

Section 16.17. Legal Actions. If the Plan Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Plan Administrator in connection with such proceeding will be paid from the assets of the Plan unless paid by the Company.

Section 16.18. Reliance. The Plan Administrator will not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Plan Administrator to be genuine or to be executed or sent by an authorized person.

Section 16.19. Misrepresentation. Any material misrepresentation on the part of the Eligible Employee making application for coverage, or reclassification of coverage, or

in applying for and/or obtaining benefits under the Plan, will render the coverage null and void ab initio.

Section 16.20. Qualified Medical Child Support Orders. The Plan will provide benefits under the applicable Benefit Programs in accordance with the applicable requirements of a qualified medical child support order, as required by Act Section 609, received by the Plan. If the Plan receives a medical child support order, the Plan Administrator will promptly notify the Eligible Employee, and each child of the Eligible Employee identified in the order, of the receipt of such order and the Plan's procedures for determining whether the order is a qualified medical child support order. If the order is a National Medical Support Order Notice, the Administrator will determine whether the Notice is appropriately completed, complete Part A or Part B of the Notice, as applicable, and return said Part(s) to the issuing agency. Within a reasonable time after receipt of such order, the Plan Administrator will determine whether the order is a qualified medical child support order and notify the Eligible Employee and each child involved of the determination. The Plan Administrator will establish written procedures in accordance with Act Section 609 to determine whether a medical child support order received by the Plan is a qualified medical child support order under the Act. Eligible Employees, dependents, and their beneficiaries may obtain, without charge, a copy of such procedures from the Plan Administrator.

Section 16.21. Eligibility for Medicaid Benefits. Benefits will be paid in accordance with any assignment of rights made by or on behalf of any Eligible Employee or dependent as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, an Eligible Employee's or dependent's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The state will have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

Section 16.22. Counterparts. This Plan may be executed in any number of counterparts, each of which will be deemed to be an original. All counterparts will constitute but one and the same instrument and will be evidenced by any one counterpart.

Section 16.23. Entire Plan. This Plan document and the documents incorporated by reference herein will constitute the only legally governing documents for the Plan. No oral statement or other communication will amend or modify any provision of the Plan as set forth herein.

SCHEDULE A

BENEFIT PROGRAMS, ELIGIBILITY ADMINISTRATORS AND CLAIMS ADMINISTRATORS

Effective as of January 1, 2020

The Plan's Benefit Programs are listed in this Schedule A. The terms and provisions of each Benefit Program are incorporated by reference. Those terms and provisions are found in the applicable sections of the applicable SPDs of each Benefit Program. The Plan Administrator or its designee shall modify this Schedule A as needed to reflect changes in Benefit Programs and/or administrative duties. This Schedule shall be updated from time to time.

Benefit Program (coverage option)	Insured	Insurance Company and Claims Administrator	Policy Number
Medical Benefits	Insured	Blue Cross Blue Shield of Illinois	B38120
Dental Benefits	Insured	Delta Dental	20380
Vision Benefits	Insured	EyeMed Vision Care	97597541001
Life and Accidental Death and Dismemberment Benefits	Insured	Cigna	118435
Long-Term Disability Benefits	Insured	Cigna	118435
Short-Term Disability Benefits	Insured	Cigna	118435
Employee Assistance Program Benefits	Self-Insured	Cigna	118435
Health Flexible Spending Accounts under the Flexible Benefits Plan	Self-Insured	Discovery Benefits	N/A

SCHEDULE B

Effective as of January 1, 2024

ADOPTING EMPLOYERS

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