RENOWN HEALTH

WELFARE BENEFITS PLAN

AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2022

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RENOWN HEALTH
WELFARE BENEFITS PLAN

ARTICLE I
ESTABLISHMENT AND PURPOSE

Section 1.01 Establishment. Effective January 1, 2022, Renown Health (the "Company") hereby amends and restates the Renown Health Welfare Benefits Plan (the "Plan") as set forth herein for the exclusive benefit of the Company's Eligible Employees (as defined below). The Plan is amended to include the Company's Code Section 125 Program. The Plan and the Code Section 125 Program are considered a single Plan for purposes of the annual Form 5500 filing requirement. The Plan is filed as plan number 501.

Section 1.02 Purpose. The purpose of the Plan is:

(a) To offer Eligible Employees an opportunity to obtain certain health and welfare benefits; and

(b) To allow Eligible Employees to elect to pay for certain health expenses on a pre-tax basis or receive taxable compensation in lieu thereof.

Benefits are provided under the Plan through the component Welfare Programs. The Plan is to be administered and interpreted in a manner consistent with the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), applicable provisions of the Internal Revenue Code of 1986, as amended (the "**Code**"), including the requirements of Sections 79, 125, 129, 105, and 223 of the Code, and the regulations promulgated thereunder. Nothing in this Plan document, however, will subject any Welfare Program to ERISA if the Welfare Program would not otherwise be covered by ERISA. The Welfare Programs not subject to ERISA are identified in Appendix A.

Section 1.03 Welfare Programs. The Plan consolidates a range of welfare plan benefits (as defined in Section 3(1) of ERISA) and the Section 125 Program. The component Welfare Programs of the Plan are set forth in Appendix A. The Administrator will maintain records as to the particular Welfare Programs from time to time forming part of the Plan and which are listed on Appendix A. Benefits are provided to Participants and their respective beneficiaries through one or more Welfare Programs sponsored or maintained by the Company.

Such Welfare Programs may be funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to certain groups of Eligible Employees (and their respective covered Dependents). Program Documents which describe the specific benefits provided by each Welfare Program, the individuals covered by each Welfare Program, and the other terms and conditions of each Welfare Program, as amended from time to time, will be incorporated herein by reference. If the Welfare Program is insured and there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Program Document will control. For all other Welfare Programs, if there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Plan will control (unless contrary to applicable law), except that any terms exclusively applicable to a Welfare Program will be set forth in the applicable Program Document.

Section 1.04 Effective Date. This Plan restatement is effective as of January 1, 2022.

Section 1.05 Annual Reporting Requirements. All Welfare Programs offered under the Plan will constitute a single "plan" for purposes of the annual reporting requirements of the Code and ERISA.

Section 1.06 Plan Document. This document, together with any and all amendments, supplements and appendices hereto, is intended to serve as the Plan's "written instrument" for purposes of Section 402 of ERISA.

ARTICLE II
DEFINITIONS

Whenever used in the Plan, the following words and phrases will have the respective meanings specified in this Section unless the context plainly requires a different meaning, and when the defined meaning is intended the term will be capitalized in the Plan.

Section 2.01 Account means a bookkeeping record maintained by the Plan with respect to each Participant which reflects, from time to time, the amounts attributable to Compensation reduction contributions made on the Participant's behalf under the Health Care Flexible Spending Account Program or Dependent Care Flexible Spending Account Program, subject to any distributions or forfeitures under such Programs. The Accounts will not be funded and will not earn or accrue any interest for the benefit of any Participant.

Section 2.02 Actively at Work means that an Employee currently works at their assigned place of employment for an Employer during assigned working hours. Notwithstanding the foregoing, an Employee shall be deemed to be Actively at Work on a day that is not a regularly scheduled work day or a day that is eligible for pay under paid time off policies of the Employer, provided that the Employee performed, in the customary manner, all of the regular duties of their job on the last preceding scheduled work day.

Section 2.03 AD&D Policy means the Company's accidental death and dismemberment insurance program, and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.04 Administrator means the Company, or its delegate.

Section 2.05 Affiliate means any corporation or other business entity which is: (a) a member of a controlled group of corporations (within the meaning of Section 414(b) or (c) of the Code) of which the Company is also a member, except that control shall be based on an interest of not less than 25%; (b) a member of an affiliated service group (within the meaning of Section 414(m) of the Code) of which the Company is also a member; (c) required to be aggregated with the Company pursuant to regulations issued under Section 414(o) of the Code; or (d) related closely enough to the Company that such corporation or entity's participation in this Plan would not be considered a "multiple employer welfare arrangement" under Section 3 of ERISA.

Section 2.06 Affordable Care Act or "ACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Code, ERISA and the Public Health Service Act ("PHSA"), and the applicable regulations promulgated from time to time pursuant thereto.

Section 2.07 Board of Directors means the board of directors of the Company or a committee thereof delegated the responsibilities with respect to this Plan.

Section 2.08 Child means a Covered Employee's: biological child, stepchild, legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support), foster child, a child for whom a Covered Employee is responsible under court order, a child for whom the Covered Employee is appointed as a legal guardian, or an eligible child for whom the Covered Employee is required to provide coverage under the terms of a Qualified Medical Child Support Order ("QMCSO") or a National Medical Support Notice ("NMSN").

Section 2.09 Claimant means any person who believes they are entitled to receive a benefit under the Plan and files a claim in accordance with the applicable Welfare Program claims procedures.

Section 2.10 Claims Administrator means:

(a) The Administrator;

(b) An entity with whom the Company has contracted to provide claim administration services with respect to participant claims under a Welfare Program; or

(c) An entity that is responsible for determining whether a particular claim is covered by such Welfare Program.

Section 2.11 COBRA means the coverage rights conferred by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and the regulations issued thereunder.

Section 2.12 Code means the Internal Revenue Code of 1986, as amended from time to time, and applicable regulations issued and effective thereunder.

Section 2.13 Committee means the committee comprised of the Chief Human Resources Officer or such other officers of the Company as may be designated by the Chief Executive Officer, that will perform the duties and responsibilities as detailed in this Plan document and, if applicable, the documents of a Component Plan.

Section 2.14 Company means Renown Health, and any successor or assignee thereof which adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan.

Section 2.15 Compensation means the total remuneration paid to the Participant by the Company for services rendered as an Employee of such entity with respect to the period during which the Employee is a Participant of this Plan for any Plan Year as reported in Box 1 of Form W-2.

Section 2.16 Covered Employee means an Eligible Employee who has enrolled in the Plan pursuant to Article 5.

Section 2.17 Covered Person (also referred to as a Participant) means any Covered Employee or Dependent who is enrolled in the Plan under a Welfare Program and who is eligible to receive benefits in accordance with the terms of the applicable Welfare Program.

Section 2.18 Dental Program means the Company's self-insured program of dental benefits, as amended from time to time.

Section 2.19 Dependent means (unless otherwise defined in the Welfare Program documents) the Covered Employee's: Spouse, Child through age twenty six (26) (regardless of financial dependency, residency with the Covered Employee, marital status, or student status) and/or unmarried Child of any age who is principally supported by the Covered Employee and who is not capable of self-support due to a physical or mental disability. A Dependent that lives outside the U.S. may be restricted from coverage under the Plan unless the Dependent has established primary residency with the Covered Employee.

Section 2.20 Dependent Care Flexible Spending Account means the Company's Dependent Care Flexible Spending Account Plan, as amended from time to time as set forth in Section VIII herein.

Section 2.21 Effective Date means the date set forth in Section 1.04 above.

Section 2.22 Election Form means such form as the Administrator may approve from time to time for the purpose of enrolling in the Plan or changing or revoking an election through the Company's on-line enrollment system. An Election Form may also be in written format if requested, but shall generally be available through the Company's on-line benefits portal. The Election Form shall authorize the Company to withhold any premiums required for coverage under the Welfare Programs from the Employee's Compensation. The Election Form may require additional information, including, but not limited to, evidence of insurability, proof of Dependent status, and/or proof of disability.

Section 2.23 Electronic Protected Health Information or EPHI has the meaning set forth in 45 C.F.R. Section 160.103.

Section 2.24 Eligible Employee means, *except as otherwise provided the Welfare Program documents* (a) a Full-Time Employee, (b) a Part-Time Employee who has been employed by the Company for thirty (30) consecutive calendar days (c) a Per Diem Employee who has worked an average of thirty (30) or more hours per week during the Initial Measurement Period or a Standard Measurement Period, and (d) solely for purposes of the Medical Program, a member of the Board of Directors of Renown Health who is not eligible group medical insurance coverage through the Board member's employer.

Section 2.25 Employee means an individual who is treated as a regular active employee of an Employer and who is paid by Employer a salary, wages or other compensation subject to statutorily required payroll tax withholding, such as federal or state income tax. The determination of whether an individual is an Employee, versus an independent contractor or any other classification of

worker or service provider and the determination of whether an individual is a member of any particular class of Employees shall be made solely by the Company and is not dependent on, nor changes due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

All other individuals will not be included within the definition of "Employee", even if one or more of such other individuals is determined by a court, the Internal Revenue Service or any other entity under any federal or state law, rule or regulations to be (or have been) a common law or statutory employee of an Employer for some or all of the period of time in question. Without limiting who is excluded, the following individuals are expressly excluded from the definition of the term "Employee":

(a) Any nonresident alien employee with no U.S. sourced income, or undocumented resident alien employee;

(b) Any individual who is performing services under an independent contractor or consultant agreement or arrangement (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee), unless a Program Document specifically provides coverage for such individuals;

(c) Any individual who must be treated as an employee for limited purposes under the leased employee provisions of Section 414(n) of the Code;

(d) Any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the Plan was the subject of good faith bargaining between the individual's bargaining representative and an Employer; or

(e) Any individual who is otherwise eligible for coverage under the Plan but has committed a fraud or misrepresentation on the Plan.

"Employee" also includes an individual who satisfied the foregoing requirements as of the date of termination of employment with the Employer and who elects to continue coverage under the Plan pursuant to COBRA.

Section 2.26 Employee Assistance Program means the Company's employee assistance program and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.27 Employer means the Company and any Affiliate of the Company that has adopted the Plan pursuant to the Plan's procedures and is listed as an adopting Employer on Appendix D attached hereto. "Company" shall not include any Affiliate that sponsors a health and welfare plan for its own employees.

Section 2.28 ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.29 FMLA means the Family and Medical Leave Act of 1993, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.30 FMLA Leave means a Leave of Absence that is required to be furnished to a Participant under the terms of the FMLA.

Section 2.31 Full-Time Employee means an Employee regularly scheduled to work thirty-six (36) or more hours per week.

Section 2.32 Group Health Plans means the following Welfare Programs:

(a) Medical Program

(b) Dental Program

(c) Vision Program

(d) Employee Assistance Program

(e) Health Flexible Spending Account Program

Section 2.33 Health Flexible Spending Account means the Account established and maintained for a Participant to record the contribution that the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses.

Section 2.34 Highly Compensated Employee, Highly Compensated Individual, and Highly Compensated Participant are defined as follows:

(a) For purposes of this Plan, "Highly Compensated Individual" means an individual who is:

(i) An officer for the preceding Plan Year (or the current Plan Year in the case of the first year of employment). Whether an individual is an officer is determined based on all the facts and circumstances, including the source of the individual's authority, the term for which he or she is elected or appointed, and the nature and extent of his or her duties. Generally, the term officer means an administrative executive who is in regular and continued service;

(ii) An owner of more than five (5) percent of the voting power or value of all classes of stock of the Employer, determined without attribution, in either the preceding Plan Year or current Plan Year; or

(iii) A highly compensated individual who for the preceding Plan Year (or the current Plan Year in the case of the first year of employment) had Compensation from the Employer in excess of the Compensation amount specified in Code Section 414(q)(1)(B), and, if elected by the Employer, was also in the top-paid group of Employees (determined by reference to Code Section 414(q)(3)).

A spouse or a dependent of any Highly Compensated Individual described above is a Highly Compensated Individual.

(b) For purposes of this Plan, "Highly Compensated Participant" means a Highly Compensated Individual who is eligible to participate in the Plan.

(c) For purposes of the Health Care Reimbursement Plan, "Highly Compensated Individual" means an individual who is (i) one (1) of the five (5) highest paid officers, (ii) a shareholder who owns (directly or indirectly) more than ten (10) percent in value of the stock of the Employer, or (iii) among the highest paid twenty five (25) percent of all Employees (other than "excludable employees" who are not Participants).

For purposes of this subsection (c), "excludable employees" means (i) Employees who have not completed three (3) years of service; (ii) Employees who have not attained age twenty five (25); (iii) part-time or seasonal Employees; (iv) Employees not included in the plan who are included in a unit of Employees covered by a collective bargaining agreement if there is evidence that accident and health benefits were the subject of good faith bargaining between Employee representatives and the Employer; and (v) Employees who are nonresident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)).

(d) For purposes of the Dependent Care Reimbursement Plan, "Highly Compensated Employee" means a person who is a highly compensated employee as defined in Section 414(q) of the Code.

Section 2.35 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as codified in Section 9801, *et seq*., of the Code, and Section 701, *et seq*., of ERISA, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.36 HIPAA Privacy Policy means the policies and procedures adopted by the Company, in its role as Plan sponsor, to memorialize compliance with HIPAA's privacy and security rules, are required under 45 C.F.R. Section 164.530(i).

Section 2.37 HIPAA Program means a Welfare Program subject to the portability and administrative simplification requirements of HIPAA, as required by Section 9801(f) of the Code.

Section 2.38 Insurance Company means an insurance company through which Welfare Program benefits are insured or which provides administrative services to a Welfare Program. For purposes of this definition, a health maintenance organization, or exclusive provider may constitute an Insurance Company. Any services agreement, master contract, or agreement to provide insurance between an Insurance Company and the Company shall not be considered a Program Document, is not incorporated herein and does not constitute part of the official Plan document.

Section 2.39 Insurance Policy means a policy issued by an Insurance Company providing insured benefit coverage under this Plan.

Section 2.40 Key Employee means a Participant who is a Key Employee within the meaning of Code Section 416(i)(1) at any time during the preceding Plan Year, including a Key Employee covered by a collective bargaining agreement.

Section 2.41 Leave of Absence means a period of Employer-approved absence from service that is not treated as a termination of employment in accordance with the Company's employment policies.

Section 2.42 Life Insurance Policy means the Company's life insurance program, and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.43 LTD Policy means the Company's long-term disability insurance program, and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.44 Medical Program means the Company's program of medical benefits, and any policies or contracts issued pursuant thereto, as amended from time to time. Medical Policy includes, but is not limited to, major medical coverage and prescription drug coverage.

Section 2.45 Medicaid means Title XIX of the Social Security Act.

Section 2.46 Medical Care Expenses means expenses incurred for "medical care" as defined by Section 213 of the Code (excluding without limitation amounts paid for a long-term care insurance contract within the meaning of Section 7702B(b) of the Code) for the treatment of the Participant or their eligible Dependents, but which expenses are not payable under any group health or dental care plan under which the individual receiving such treatment is covered. "Medical Care Expenses" do not include premiums for medical coverage but may include deductibles and co-payments.

Section 2.47 Medicare means Part A, B or D of Title XVIII of the Social Security Act.

Section 2.48 MHPAEA means the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as codified at ERISA Section 712 and Code Section 9812, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.49 Part-Time Employee means an Employee regularly scheduled to work between twenty (20) hours and thirty-five (35) hours per week.

Section 2.50 Participant means an Eligible Employee or eligible Dependent who participates in a Welfare Program.

Section 2.51 Participating Employer means (i) the Company or (ii) an Affiliate that has adopted this Plan with the consent of the Company and has not terminated participation or withdrawn from the Plan. Each Participating Employer is listed on Appendix C. The Employer shall amend Appendix C as needed, to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix C may be made by any authorized officer or representative of the Employer and shall not require approval

of the Board of Directors. Where this Plan delegates any duty or authority to a Participating Employer, such authority may be exercised, and such duty performed by an agent designated by the Participating Employer

Section 2.52 Participation Agreement means the agreement executed between an Affiliate and the Company that establishes the Affiliate's adoption of the Plan for the benefit of its Eligible Employees, as described in Section 16.01.

Section 2.53 Per Diem Employee means an Employee hired to work on a per diem basis and who is not classified as a Full-Time Employee or Part-Time Employee by the Employer.

Section 2.54 Plan means the Renown Health Welfare Benefits Plan, as set forth herein, together with any and all amendments, supplements and appendices hereto.

Section 2.55 Plan Year means the twelve (12) month period beginning each January 1st and ending each December 31st.

Section 2.56 Program Document means the written description of the terms of each separate Welfare Program, including but not limited to a summary plan description, schedule of benefits, benefits booklet, or Insurance Policy.

Section 2.57 Protected Health Information or PHI has the meaning set forth in 45 C.F.R. Section 160.103.

Section 2.58 QMCSO or Qualified Medical Child Support Order means a court order requiring coverage of an Eligible Employee's Child under a Group Health Program that satisfies the requirements of ERISA Section 609. A National Medical Support Notice (NMSN) issued by a state or local child welfare agency will also be considered a QMCSO if it otherwise meets the requirements of a QMCSO as determined by the procedures established by the Administrator.

Section 2.59 QRD or Qualified Reservist Distribution means a distribution to an individual of all or a portion of the balance in the individual's Health Flexible Spending Account if:

(a) The individual is a member of a reserve component ordered or called to active duty for a period of one hundred and eighty (180) days or more or for an indefinite period; and

(b) The request for a distribution is made during the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call to active duty.

Section 2.60 Section 125 Program means the Benefits Program sponsored by the Company, which permits Eligible Employees to elect to pay their share of the required premiums for Welfare Program coverage on a pre-tax basis. The Section 125 Program is intended to qualify as a "cafeteria plan" under Section 125 of the Code. Only qualified benefits as defined in Section 125(f) of the Code will be offered under the Section 125 Program.

Section 2.61 Short-Term Disability Policy means the means the Company's short-term disability insurance program, and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.62 Spouse means an individual legally married to a Participant. Spouse does not include an individual who is legally separated from a Participant, unless recognized under the applicable Program Document or required by law. Spouse does not include a common law spouse, unless otherwise provided for in an applicable Program Document.

Section 2.63 Summary Health Information means information:

(a) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and

(b) From which the information described at 42 C.F.R. Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Section 2.64 Tax Code Dependent means an individual who qualifies as the Covered Employee's "dependent" for the particular purpose under Section 152 (and any other applicable provision(s)) of the Code. For purposes of the Health Flexible Spending Account and any Welfare Program providing "medical care" (within the meaning of Section 213(d) of the Code), a "Tax Code Dependent" means an individual who qualifies as a "dependent" of the Covered Employee under Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; provided that, the term "Tax Code Dependent" for these purposes will also mean any child (as defined in Section 152(f)(1) of the Code) of the Covered Employee who, as of the end of the taxable year, has not attained age 27. Any child to whom Section 152(e) of the Code applies will be treated as a Tax Code Dependent of the Covered Employee for these purposes.

Section 2.65 Third Party means any person or entity who is or may be liable for an injury, illness, disability, or death of a Covered Person including without limitation, an insurance company for such third party or a potentially liable person or entity; worker's compensation; homeowner's insurance; all coverages under an automobile policy of the Covered Person or a member of the Covered Person's family, including "no fault" coverage, medical coverage, and uninsured or underinsured motorist coverage; and other similar coverages. If appropriate under the circumstances, the Covered Person or any insurer of the Covered Person may be considered a Third Party if the Covered Person is or may be responsible for the injury, illness, disability or death of a Covered Person and/or the Covered Person has insurance coverage for such injury, illness, disability or death.

Section 2.66 Uniformed Service means the performance of duty on a voluntary or involuntary basis under competent authority, and includes active duty, inactive duty for training, initial active duty for training, full-time National Guard duty, and a period during which an Employee is absent from employment with an Employer for the purpose of an examination to determine the fitness of the Employee to perform any such duty in the United States Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training

or full-time National Guard duty), the commissioned corps of the Public Health Service and any other category of person designated by the President of the United States in time of war or emergency.

Section 2.67 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time

Section 2.68 Vision Program means the Company's program of vision benefits, which may be provided through self-insurance or by an insurance company, health maintenance organization, or other third party provider, and any policies and contracts issued pursuant thereto, as amended from time to time.

Section 2.69 Welfare Program means a welfare benefit program or arrangement which is sponsored by the Company and which forms part of the Plan. The component Welfare Programs offered through the Plan are set forth in Appendix A. The Company, in its discretion, may adopt or amend the component Welfare Program Document from time to time.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Section 3.01 Employee Eligibility. The requirements for Eligible Employees to participate in the Plan are set forth in the specific Program Documents and summarized on Appendix B attached hereto.

Section 3.02 Dependent Eligibility. Dependents are eligible to participate in the Plan only to the extent their related Eligible Employee enrolls as a Participant. If an Eligible Employee does not enroll in the Plan, such Eligible Employee's Dependents are not eligible to participate in the Plan.

In the event both Spouses are Eligible Employees, each Spouse may enroll separately for coverage under the Plan, or each Eligible Employee enrolled under the Plan may enroll as a Dependent of the other under the Plan. However, the combined maximum contractual benefits to which both Eligible Employees and their Dependents are entitled to under the Plan shall not exceed the individual maximum benefit amounts payable under any applicable Welfare Programs.

The Plan Administrator reserves the right to confirm Dependent eligibility and may request certain evidence of eligibility from the Covered Employee (such as a copy of a marriage certificate that must be submitted within a designated time period in order for a Dependent to continue coverage under the Plan.

Section 3.03 Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Program Document, in no event will an individual be covered as both a Participant and a Dependent, or a Dependent be covered as a Dependent of more than one Participant.

Section 3.04 Participation Conditions. As a condition of participation and receipt of benefits under this Plan, each Participant shall:

(a) Timely enroll in the Plan to the Administrator in accordance with Article V;

(b) Designate a portion of their Compensation, if any, as a contribution to the Plan in accordance with Article IV and consent to have such amount withheld as a salary reduction contribution;

(c) Observe all Plan rules and regulations, including accurate and truthful completion of the Plan's Dependent verification process;

(d) Consent to the Administrator's inquiries with respect to any physician, hospital, or other medical care provider or other services involved in a determination for eligibility of coverage or a benefits claim under the Welfare Programs, or for reimbursement of Medical Expenses; and

(e) Submit to the Administrator all reports, bills, and other information that the Administrator may reasonably require, including written substantiation by a third party (to the satisfaction of the Administrator) of the amount of any Medical Expense to be reimbursed, and a written statement by the Participant that such expense is not reimbursable through other sources.

Section 3.05 Termination of Participation.

(a) Except as otherwise specifically provided herein or in the applicable Program Document, coverage under the Plan for a Covered Employee will terminate when the first of the following events occurs:

(i) The Covered Employee ceases to be an Employee of any Employer;

(ii) The Covered Employee is no longer eligible to participate in the Plan;

(iii) The Covered Employee fails to timely pay any required Participant contributions;

(iv) The Covered Employee elects not to participate in a Welfare Program for the subsequent Plan Year during Annual Enrollment;

(v) The Company terminates the Welfare Program or amends the Welfare Program in a manner that it no longer applies to the Covered Employee or Dependent;

(vi) The date that the Covered Employee commits an intentional misrepresentation or fraud on the Plan.

(b) Except as otherwise specifically provided herein or in the applicable Program Document, coverage under the Plan for a covered Dependent will terminate when the first of the following occurs:

(i) The Covered Employee ceases to be covered; or

(ii) The covered Dependent is no longer an eligible Dependent; or

(iii) The date that the Dependent commits an intentional misrepresentation or fraud on the Plan.

(c) In the event that active coverage under a Welfare Program terminates upon one of the events identified in Section 3.05 (a) or (b) above, such termination will be effective as of the date of the event, unless otherwise set forth in the relevant Program Document.

Section 3.06 Effect of Termination. Notwithstanding any provision of the Plan to the contrary, a Covered Employee who terminates employment with the Company may, as applicable, receive benefits after such termination in accordance with Article IX. To the extent that a Participant's termination constitutes a Change in Status, the Participant may modify or revoke their prior Plan elections in accordance with Section 5.06(a).

Section 3.07 Continuation of Participation during a Leave of Absence.

(a) Participation in the Plan During Leaves of Absence. Participation during a Leave of Absence may continue pursuant to the terms and conditions of the Welfare Programs and the Company's leave policies. To the extent that the Leave of Absence constitutes a Change in Status, the Participant may modify their Plan election as provided in Section 5.06(a). Notwithstanding the foregoing, a Participant will only be allowed to maintain coverage under the Plan while on a Leave of Absence if the Participant continues to have an employment relationship with the Company, maintains their eligibility to participate in the applicable Welfare Program, and makes all required Participant contributions, to the extent required by this Article, the Company's Leave of Absence policy, and the applicable Program Documents. Active coverage under the Plan will end during a Leave of Absence on the earlier of: (i) the date set forth in the applicable Welfare Program, (ii) the day the Covered Employee does not return to Active Service when the approved Leave of Absence ends, or (iii) the date coverage otherwise ends under Section 3.05(a) above.

(b) Contributions During Leaves of Absence. If a Welfare Program requires a Covered Employee to continue contributions while they are on a Leave of Absence, the Covered Employee must make timely contributions in the form and manner prescribed by the Administrator, as described above. If the Covered Employee fails to timely make such required contributions during their Leave of Absence due to unforeseen hardship, the Administrator shall have sole discretion to allow the Covered Employee to make such contributions retroactively upon the Covered Employee's return to Active Service (to the extent permitted by relevant federal and/or state or local law, if applicable). The Administrator shall also have sole discretion to retroactively reinstate the Covered Employee's coverage under such Welfare Program if the Covered Employee's coverage terminated due to the failure to make timely contributions pursuant to an unforeseen hardship. Such retroactive contributions will be made according to a schedule determined by the Administrator.

(c) USERRA. If a Covered Employee is entitled to the protection of USERRA when taking a Leave of Absence to perform Uniformed Service, their benefits shall be administered in accordance with the USERRA.

(d) FMLA. A Covered Employee who takes an unpaid Leave of Absence under the FMLA (or other state or local leave law, if applicable) will continue to participate in their elected

Welfare Programs while on such Leave of Absence as provided above in Section 3.07(a). If premiums are changed while a Covered Employee is on such Leave of Absence, the Covered Employee will pay the new premium rates. If the Covered Employee fails to timely pay the required cost of coverage in accordance with Department of Labor regulations issued under the FMLA, the Covered Employee's coverage under the Welfare Programs may be terminated in accordance with such regulations.

(i) Company's Right to Recoup Contributions. The Company has the right to recover contributions it pays for maintaining group health plan coverage during a Covered Employee's unpaid Leave of Absence when the Covered Employee fails to return to work after such Leave of Absence ends. For purposes of the foregoing, a Covered Employee who returns to work for at least thirty (30) days is considered to have "returned" to work. The Company will not have any such right, however, if the Covered Employee's failure to return to work is due to:

(A) A serious health condition of the Covered Employee or their family which would entitle the Covered Employee to a Leave of Absence under the FMLA; or

(B) Other circumstances beyond the Covered Employee's control, such as the Covered Employee's Spouse unexpectedly being transferred to a job location more than (seventy five)75 miles from the Covered Employee's work site, a relative or individual other than an immediate family member having a serious health condition and the Covered Employee being needed to provide care, or the Covered Employee being laid off while on leave. (Circumstances beyond the Covered Employee's control do not include a mother deciding not to return to work to stay home with a newborn child or a Covered Employee remaining in a distant location with a parent who no longer requires the Covered Employee's care.)

(C) If a Covered Employee does not return to work because of the reasons provided in subparagraph (1) or (2) above, the Company may require medical certification of the Covered Employee's or family member's serious health condition. If the Covered Employee does not provide such certification within thirty (30) days of the Company's request the Company may recover from the Covered Employee group health plan contributions paid during the period of an unpaid Leave of Absence.

(e) Relationship with COBRA. A "qualifying event" for purposes of COBRA continuation coverage may occur if, after the end of an unpaid Leave of Absence, a Covered Employee does not return to work and, but for COBRA continuation coverage, that Covered Employee would lose group health coverage. In such a case, the qualifying event will be deemed to have occurred on the last day of the Covered Employee's active coverage as set forth in 3.07(a) above, and the Covered Employee may elect COBRA continuation coverage provided the Covered Employee has continued to timely make any required premiums or otherwise agreed to repay any owed premium contributions.

Section 3.08 Reinstatement of Former Covered Employee.

(a) Rehires. Except as provided in Article XI, a Covered Employee who terminates employment will be deemed to have revoked their election and terminated their receipt of benefits

under this Article with respect to expenses incurred after the date of such employment termination. If a Covered Employee who terminates employment is rehired within thirty one (31) days, the Covered Employee's prior election will be automatically reinstated provided they are still eligible. If a Covered Employee is rehired more than thirty one (31) days after termination of employment, but less than thirteen (13) weeks following the termination date, the rehired Employee may continue coverage under the Group Health Plans as set forth in the Program Documents or make a new election in accordance with Article V, provided they are still eligible. In addition, a rehired Employee may make an election that corresponds with the special enrollment rights set forth in Section 5.05. With respect to the Health Flexible Spending Account, if a Covered Employee is rehired within thirty one (31) days, the Covered Employee will have access to the full amount designated by the Covered Employee to be credited to such Account for that entire Plan Year, and the Covered Employee will be required to make up any contributions missed during the period of termination of employment.

(b) After FMLA Leave. Upon returning from FMLA leave, if coverage terminated while on FMLA leave (either by revocation or nonpayment of any required Covered Employee contribution), the Employee may choose to prospectively reinstate their election for coverage under any Group Health Plan (as defined in Section 5000(b) (1) of the Code), including the Health Flexible Spending Account. If the Employee does not elect to reinstate their election for coverage under any Group Health Plan, the Company may nevertheless require the Employee to resume participation if the Company also requires Employees returning from unpaid non-FMLA leave to resume participation upon return from a non-FMLA Leave of Absence.

ARTICLE IV
BENEFIT CHOICES AND CONTRIBUTIONS

Section 4.01 Welfare Programs.

(a) The Welfare Programs offered under the Plan are listed on Exhibit A and the Program Documents are incorporated herein by reference.

(b) Welfare Programs which do not require Participant contributions will be automatically available to Employees who are eligible under the terms of the applicable Welfare Program. An Eligible Employee may also elect under this Plan to obtain coverage under the optional Welfare Programs for which they are eligible in accordance with the procedures described in Article V. If an Eligible Employee so elects, a portion of their Compensation will be applied by the Company on a pre-tax or after-tax basis (as the case may be) to satisfy the Participant cost of such optional Welfare Programs. While a Participant's election to receive and pay for certain benefits may be made under this Plan, the benefits will be provided pursuant to the applicable underlying Program Documents.

Section 4.02 Participant Contributions Required for Plan Coverage. The Company will determine whether any of the Welfare Programs will require Participants to contribute toward the cost of coverage and the cost of such coverage. Any Welfare Programs which require Participant contributions are optional Welfare Programs. The Company will establish the cost of coverage applicable to Participants under the optional Welfare Programs, may adjust such costs from time

to time, and will determine whether such costs are to be paid by the Participants on a pre-tax or an after-tax basis. Participants will be required to contribute such cost of coverage by automatic reduction of the Participant's Compensation on a pre-tax or after-tax basis, as applicable. Compensation reductions to pay for the cost of coverage will begin effective as of the first period for which the optional coverage is effective. The Company will track the Participant contributions and apply them toward the cost of coverage for the optional Welfare Program.

ARTICLE V
ENROLLMENT AND ELECTIONS

Section 5.01 Enrollment Process.

(a) Initial Enrollment. Each Employee who becomes eligible to participate in an optional Welfare Program under the Plan will be furnished with enrollment materials and given the opportunity to elect to participate in the Plan. A Participant's enrollment will become effective pursuant to the provisions of the applicable Welfare Program.

(b) Mid-Year Enrollment. Any individual who was not eligible to participate as of the first day of a Plan Year but who becomes eligible to participate in the Plan during that Plan Year may elect to participate in the Plan. Such individual must submit a completed Election Form within thirty (30) days of becoming eligible to participate in the Plan through the on-line enrollment system. If such an individual fails to submit a completed Election Form within such thirty (30) day period, such individual will be treated as waiving their right to participate in the optional Welfare Programs under the Plan for the remainder of such Plan Year, subject to Sections 5.05 and 5.06.

Contingent upon the timely submission of an Election Form with the Administrator, mid-year enrollment under this Section will become effective for claims incurred on or after the date the new Participant becomes eligible to participate in the Plan. Salary reductions to pay for the cost of coverage elected under this Section will begin in the payroll period coinciding with or next following the effective date of mid-year enrollment and will be for coverage periods from the date of mid-year enrollment.

(c) Initial Enrollment for Subsequent Plan Years. Any Employee who is eligible to participate but who previously waived or revoked participation may commence participation in the Plan as of the start of a subsequent Plan Year by submitting an Election Form through the Company's on-line enrollment system, within the designated enrollment period. The Employee may also be required to submit evidence of insurability, if necessary, and complete any Dependent verifications required by the Plan. Any election made under this Section 5.01(c) will be subject to the terms of the underlying Program Document.

Section 5.02 Annual Enrollment. Before the first day of each Plan Year, each Eligible Employee, each Eligible Employee on an approved Leave of Absence and each COBRA qualified beneficiary (as described in Section 10.02) will be given the opportunity to elect to participate in the optional Welfare Programs for the next Plan Year through the Company's on-line enrollment system at the time and in the manner required by the Plan Administrator. (An Employee's entitlement to a Welfare Program other than a Group Health Plan benefit while on FMLA leave will be determined

by the Employer's policies for providing such benefits while an Employee is on a non-FMLA leave.) A current description of the Welfare Programs for which the Employee would be eligible if they elected to participate will also be furnished to the Participant before or at the start of the election period, as well as any additional required information, including, but not limited to, evidence of insurability and proof of Dependent status. To be valid, the Election Form must be completed and submitted on or before the end of the designated election period for the Plan Year to which it applies.

(a) The Election Form shall allow Eligible Employees to (i) designate the optional Welfare Programs in which they elect to participate for the applicable Plan Year, (ii) designate the applicable level of coverage under such Welfare Program, (iii) designate the identity of any Dependents to be covered, and (iv) authorize the Company to withhold the applicable Welfare Program contributions from the Eligible Employee's Compensation.

(b) If an Eligible Employee has medical coverage through another group health plan such as through the employer of the Employee's spouse, the Employee may elect to waive coverage under the Medical Program.

(c) The Election Form will take effect as of the first day of such Plan Year and will remain in effect throughout the Plan Year unless modified or revoked in accordance with Section 5.05 or 5.06. Each Participant's Election Form will be valid for one Plan Year and must be renewed from Plan Year to Plan Year subject to the requirements of Section 5.04(b).

Section 5.03 Election Forms. Elections and revocations of elections will be made on an Election Form available through the on-line enrollment system, in accordance with such rules as may be provided or established from time to time by the Administrator. The Administrator will make Election Forms available to Eligible Employees or Participants (a) upon request, (b) within a reasonable time following an Employee's date of hire and before an Employee becomes a Participant, and (c) within a reasonable time before the beginning of each Plan Year.

Section 5.04 Failure to Return Election Form.

(a) Initial Election. If a current Eligible Employee or Qualified Beneficiary fails to submit a completed Election Form on or before the specified due date for the initial Plan Year, the Eligible Employee will automatically be enrolled in the lowest cost "Employee Only" Medical Program option under the Plan and such Eligible Employee will be deemed to have elected not participate in any other Welfare Programs for the remaining period of the initial Plan Year.

(b) Failure to Submit Election Form During Annual Enrollment. A Covered Employee's or an Eligible Employee's failure to return a completed Election Form to the Administrator during an Annual Enrollment on or before the specified due date for any subsequent Plan Year, will be deemed an election to continue the Covered Employee's prior year elections with respect to all Welfare Programs other than the Health FSA, and Dependent Care FSA. (the "Account Programs"). The Covered Employee will be deemed to have elected not to participate in the Account Programs for the subsequent Plan Year. Eligible Employees may not enroll in the Plan after the beginning of the Plan Year except as otherwise set forth in Sections 5.05 and 5.06 below.

Section 5.05 Special Enrollment Rules. Notwithstanding anything contained herein to the contrary, if an Eligible Employee does not timely enroll in a HIPAA Program when such program would otherwise permit the Eligible Employee to enroll themselves (and/or their eligible Dependents) and the Eligible Employee subsequently wishes to elect such coverage, the Eligible Employee may do so in appropriate circumstances under these special enrollment rules.

(a) Loss of Coverage. An Eligible Employee may enroll for coverage under a HIPAA Program for the Eligible Employee and their Dependents if the requirements of Treasury Regulation 54.9801-6(a)(2) are satisfied due to a loss of other coverage. In this case, the Eligible Employee must enroll and provide supporting documentation of the event within thirty (30) days after the date on which:

(i) COBRA continuation coverage was exhausted, or

(ii) The coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage.

Enrollment in a HIPAA Program pursuant to this paragraph will be effective the day of the event listed above in this Section 5.03(a), provided the Eligible Employee enrolls in the Plan and provides documentation substantiating the event within thirty (30) days after such relevant event.

(b) New Dependent. In addition, an Eligible Employee may enroll for coverage under a HIPAA Program for themselves and their eligible Dependents if (i) the Eligible Employee is eligible for Medical Program, but is not currently enrolled, or is currently enrolled but the new Dependent is not currently enrolled; and (ii) another individual (a Spouse or child) has become a Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

In this case, the Eligible Employee must enroll and provide and substantiating documentation within thirty (30) days after the marriage, birth, adoption, or placement for adoption unless a Welfare Program allows a longer period of time. Enrollment in a HIPAA Program pursuant to this Section will be effective as of the date of the event, provided the Employee enrolls in the Plan and provides documentation substantiating the event within thirty (30) days after the date of the event.

If an Eligible Employee does not notify the Administrator within thirty (30) days after gaining a newly eligible Dependent and provide documentation substantiating the event, the Employee may not add the newly eligible Dependent to their coverage until the next Annual Enrollment period or the next time a special enrollment rule is triggered. Notwithstanding the foregoing, the Plan will comply with any suspended special enrollment deadlines required pursuant to Federal law.

(c) Medicaid or SCHIP. An Employee who is eligible for health coverage under a HIPAA Program but is not currently enrolled may enroll for health coverage under that program: (1) for the Employee if the Employee experiences an event described in (i) or (ii) below, or (2) for the Eligible Employee and each of their Dependents experiencing an event described in (i) or (ii) below. An Eligible Employee who is currently enrolled in health coverage under a HIPAA Program,

but their Spouse and/or one or more Dependents are not enrolled in such HIPAA Program, may enroll in such HIPAA Program each Spouse or Dependent experiencing an event described in (i) or (ii) below.

(i) Termination of Coverage. The Eligible Employee or Spouse or Dependent is covered under Medicaid or a State Children's Health Plan and that coverage is terminated as the result of loss of eligibility for such coverage.

(ii) Eligibility for Assistance. The Eligible Employee or Spouse or Dependent becomes eligible for assistance with respect to coverage under the HIPAA Program under Medicaid or a State Children's Health Plan.

The Eligible Employee must enroll within sixty (60) days after the date on which the event in (i) or (ii) above occurs. Enrollment in a HIPAA Program pursuant to this subsection (c) will be effective as of the day of the relevant event provided the Employee has completed such enrollment within the sixty (60) day period. If the Eligible Employee does not enroll within sixty (60) days of the event, the Employee may not enroll for coverage or add the eligible Spouse or Dependent to their coverage until the next Annual Enrollment period or the next time a special enrollment rule is triggered. Notwithstanding the foregoing, the Plan will comply with any suspended special enrollment deadlines required pursuant to Federal law.

(d) QMCSOs. The Administrator will be permitted to modify an Eligible Employee's election to provide coverage under an accident or health plan for a Child who is a Dependent of the Eligible Employee if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. An Eligible Employee will be permitted to revoke his or her election for the Plan Year and make a new election to provide for or cancel coverage for the Child if the order requires the Spouse, former Spouse or other individual to provide coverage for the Child. The Administrator, in its sole discretion, will determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. The Eligible Employee's new election will take effect as of the effective date provided in the QMCSO Procedures established by the Administrator.

Section 5.06 Modifying and Revoking Elections. Except as provided in this Section 5.06, a Covered Employee's election made under this Article will be irrevocable after the end of the election period. If a Covered Employee fails to make required contributions at any point during a Plan Year, their election will be deemed to have been revoked, and benefits will cease. A Covered Employee may only change their Benefit Elections outside of the Annual Enrollment period in the following circumstances:

(a) The Covered Employee experiences a change in status, as follows, provided that the consistency rules of paragraph (b), below, are satisfied:

(i) Legal Marital Status. Events that change an Eligible Employee's legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment;

(ii) Number of Dependents. Events that change an Eligible Employee's number of dependents (as defined in Treasury Regulation Section 1.125-4), including birth, adoption, placement for adoption (as defined in regulations under Code Section 9801), or death of a Dependent;

(iii) Employment Status. Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's Spouse, or the Eligible Employee's Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid Leave of Absence; and a change in work site. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer or an employee benefit Plan of the Eligible Employee's spouse, or dependent depend on the employment status of the Eligible Employee and there is a change in that individual's employment status with the consequence that he or she becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this paragraph (iii);

(iv) Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents: An event that causes an Eligible Employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, the change in the law permitting coverage of adult children who, at the end of the taxable year, have not attained age twenty six (26), or any similar circumstance; and

(v) Residence. A change in the place of residence of the Eligible Employee, spouse, or dependent to the extent that the individual's new residence is outside the service area of a Benefit Plan option in which the individual is enrolled.

(b) Consistency Rules.

(i) Application to Accident or Health Coverage. A benefit election change satisfies the requirements of this paragraph (b) with respect to accident or health coverage, only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under such plan. A change in status that affects eligibility under such plan includes a change in status that results in an increase or decrease in the number of an Employee's family members or dependents who may benefit from coverage under that plan.

(ii) Application to Other Qualified Benefits. A benefit election satisfies the requirements of this paragraph (b) with respect to the Dependent Care Reimbursement Plan, if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under such plan. An election change also satisfies the requirements of this paragraph (b) if the election change is on account of and corresponds with a change in status that affects expenses described in Section 129 of the Code.

The consistency requirements of this paragraph (b) shall be applied to circumstances not described above in a manner that constitutes a reasonable, good faith interpretation of the rule that both the revocation of an original benefit election and a new benefit election must be on account of and consistent with a change in family status. Furthermore, the Plan

shall be administered in accordance with such regulations and rulings as may be published by the Internal Revenue Service.

(iii) Application of Consistency Rule. If the change in status is the Eligible Employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an Eligible Employee's election under the Plan to cancel health or accident coverage under an Employer's benefit plan for any individual other than the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the Employee's election or cancellation of health or accident coverage under an Employer's plan for any other dependent, for the Eligible Employee, or for the Eligible Employee's spouse fails to correspond with that change in status. In addition, if an Eligible Employee, Spouse, or Dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, an Employee's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

(iv) Exception for COBRA. If the Eligible Employee, Spouse, or Dependent becomes eligible for continuation coverage under a group health plan as provided in Code section 4980B or any applicable similar law, the Plan may permit the Employee to elect to increase payments under the Plan in order to pay for the continuation coverage.

(c) Judgment, Decree, or Order. This paragraph (c) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO or NMSN) that requires accident or health coverage for an Eligible Employee's Child. Notwithstanding the provisions of paragraph (b) of this section, the Plan may—

(i) Change the Eligible Employee's election to provide coverage for the Child if the order requires coverage for the child under the Employer's Plan; or

(ii) Permit the Eligible Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse or other individual to provide coverage for the Child and that coverage is, in fact, provided.

(d) Entitlement to Medicare or Medicaid. If an Eligible Employee, Spouse, or Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan may permit the Eligible Employee to make an election change to cancel or reduce coverage of that Eligible Employee, spouse or dependent under such plans. In addition, if an Eligible Employee, spouse, or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan may permit the Eligible Employee to make a

prospective election to commence or increase coverage of that Eligible Employee, spouse, or dependent under the accident or health plan.

(e) Significant Cost or Coverage Changes.

(i) In General. Paragraphs (e) through (h) of this section set forth rules for election changes as a result of changes in cost or coverage.

(ii) Automatic Cost Changes. If the cost of a Welfare Program increases (or decreases) during a period of coverage and, under the terms of the Welfare Program, Covered Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Covered Employees' elective contributions for the Welfare Program.

(iii) Significant Cost Changes. If the cost charged to a Covered Employee for a Welfare Program option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Covered Employee to make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that Welfare Program and, in lieu thereof, either receiving on a prospective basis coverage under another Welfare Program option providing similar coverage or dropping coverage if no other Welfare Program providing similar coverage is available.

(iv) Application of Cost Changes. For purposes of paragraphs (e)(ii) and (iii) of this subsection (e) a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Covered Employee or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Employees).

(f) Coverage Changes.

(i) Significant Curtailment Without Loss of Coverage. If a Covered Employee (or a Covered Employee's Spouse or Dependent) has a significant curtailment of coverage under a Benefit Plan during a period of coverage that is not a loss of coverage as described in paragraph (f)(ii) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under an accident or health plan), the Plan may permit any Covered Employee who had been participating in the Welfare Program and receiving that coverage to revoke their election for that coverage and, in lieu thereof, to elect to receive on a prospective basis coverage under another Benefit Plan option providing similar coverage, if any. Coverage under a Welfare Program is significantly curtailed only if there is an overall reduction in coverage provided under the Welfare Program so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

(ii) Significant Curtailment With Loss of Coverage. If a Covered Employee (or their covered Dependent) has a significant curtailment that is a loss of coverage, the Covered Employee may revoke their election under the Plan and, in lieu thereof, elect either to receive on

a prospective basis coverage under another Welfare Program providing similar coverage, if any, or to drop coverage if no similar Welfare Program is available. For purposes of this paragraph (f)(ii), a loss of coverage means a complete loss of coverage under the Welfare Program or other coverage option (including the elimination of a Welfare Program or the individual losing all coverage under the Plan by reason of an overall lifetime or annual limitation). In addition, the Plan may, in its discretion, treat the following as a loss of coverage:

(A) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Covered Employee or their covered Dependent is currently in a course of treatment; or

(C) Any other similar fundamental loss of coverage.

(iii) Addition or Improvement of a Welfare Program Option. If a Welfare Program adds a new other coverage option, or if coverage under an existing other coverage option is significantly improved during a period of coverage, the Plan may permit Eligible Employees (whether or not they have previously made an election under the Plan or have previously elected the benefit package option) to revoke their election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved coverage option.

(g) Change in Coverage Under Another Employer Plan. The Plan may permit an Eligible Employee to make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or of another employer) if:

(i) The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under this section (disregarding this paragraph (g)(i)); or

(ii) The other plan permits its participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

(h) Loss of Coverage Under Other Group Health Coverage. The Plan may permit an Eligible Employee to make an election on a prospective basis to add coverage for the Eligible Employee or Dependent if they lose coverage under any group health coverage sponsored by a governmental or educational institution, including (i) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, (ii) a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization, (iii) a State health benefits risk pool, or (iv) a Foreign government group health plan.

(i) Family and Medical Leave Act. A Covered Employee taking FMLA Leave may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(j) Special Enrollment Rights. A Covered Employee may revoke an election for group health plan coverage during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).

(k) Reduction in Hours of Service. A Covered Employee may make a prospective election change under a Group Health Plan (excluding the Health FSA) and that provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) provided the following conditions are met:

(i) The Covered Employee has been in an employment status under which the Employee was reasonably expected to average at least thirty (30) hours of service per week and there is a change in the Employee's status so that the Employee will reasonably be expected to average less than thirty (30) hours of service per week after the change, even if that reduction does not result in the Covered Employee ceasing to be eligible under the Group Health Plan; and

(ii) The revocation of the election of coverage under the Group Health Plan corresponds to the intended enrollment of the Covered Employee and Dependents who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Plan may rely on the reasonable representation of a Covered Employee who is reasonably expected to have an average of less than thirty (30) hours of service per week for future periods that the Covered Employee and Dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(l) Enrollment in a Qualified Health Plan. A Covered Employee may make a prospective election change under a Group Health Plan that is not a health flexible spending account and that provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) provided the following conditions are met:

(i) The Covered Employee is eligible for a special enrollment period to enroll in a qualified health plan through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act (a "Marketplace") pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Covered Employee seeks to enroll in such a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Covered Employee and Dependents who cease

coverage due to the revocation in a qualified health plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Plan may rely on the reasonable representation of a Covered Employee who has an enrollment opportunity for a qualified health plan through a Marketplace that the Covered Employee and related individuals have enrolled or intend to enroll in a qualified health plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(m) Other Events. A change in status shall also include such other events as the Plan Administrator determines will permit a change or revocation of a benefit election during the Plan Year under such regulations as may from time to time be promulgated by the Commissioner of the Internal Revenue Service.

(n) QMCSOs. The Administrator will be permitted to modify an Eligible Employee's election to provide coverage under an accident or health plan for a child or foster child who is a Dependent of the Employee if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. An Employee will be permitted to revoke their election for the Plan Year and make a new election to provide for or cancel coverage for the child if the order requires the Spouse, former Spouse or other individual to provide coverage for the child. The Administrator, in its sole discretion, will determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. The Employee's new election will take effect as of the effective date provided in the QMCSO Procedures established by the Administrator.

(o) Enrollment in Marketplace Coverage. If a Covered Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, the Employee may revoke their medical Welfare Program election for the Plan Year in a manner consistent with the Covered Employee's intended enrollment in such Qualified Health Plan. Such Marketplace coverage must be effective beginning no later than the day immediately following the last day of coverage under this Plan. For purposes of this Section 5.06(i), the terms "Special Enrollment Period," "Qualified Health Plan," and "Marketplace" shall have the meanings described in IRS Notice 2014-55.

Section 5.07 Procedure for Modifying Election. An Eligible Employee will make election changes under this Article by filing a new Election Form and providing substantiating documentation of the event with the Administrator within thirty one (31) days (or such longer time as the Administrator may allow) after the date of the applicable event (or for certain special enrollment events, within sixty (60) days of the date of the event, but only to the extent required under HIPAA) described in the applicable subsection. Except as provided by the Plan, such election changes and new contribution levels will become effective as soon as administratively feasible after the Eligible Employee files their Election Form with the Administrator retroactive to the effective date coverage was modified. Alternatively, an Eligible Employee may prospectively complete and submit an Election form prior to the date of the event that gives rise to the mid-year election change.

Section 5.08 Nondiscrimination Requirements.

(a) The Administrator may periodically conduct such testing as it deems necessary to comply with the nondiscrimination requirements under Sections 79, 105(h) and 125 of the Code. The Administrator has the right to adjust any Participant's Compensation reduction election made under this Article at any time and from time to time (i) to ensure that the Plan complies with any applicable nondiscrimination requirements under Sections 79, 105(h) and 125 of the Code, and (ii) to rectify erroneous Compensation reductions, contributions and credits.

(b) The Plan will not provide any statutory non-taxable benefits in a Plan Year to key employees (as defined in Section 416(i)(1) of the Code) in excess of twenty five (25) percent of the aggregate of such benefits provided to all Employees under the Plan. For purposes of the preceding sentence, qualified benefits will not include benefits which (without regard to this Section) are includable in the Participant's gross income.

(c) For purposes of this Section 5.08, statutory non-taxable benefits include qualified benefits (as defined in Code Section 125(f) and applicable regulations) that are excluded from income. Statutory non-taxable benefits also include group-term life insurance on the life of an Employee includable in the Employee's gross income solely because the coverage exceeds the limit in code Section 79(a).

ARTICLE VI
FUNDING AND ACCOUNTS

Section 6.01 Funding.

(a) The Welfare Programs may be funded through Insurance Policies, from the general assets of the Company or otherwise, in accordance with the various documents forming part of the Plan and the respective Welfare Programs. The benefits provided by the Welfare Programs will be supported by the contributions of the Employer and Participants, as the case may be, in accordance with the Program Documents for the respective Welfare Programs. To the extent that a trust agreement or insurance contract funds part or all of the benefits provided by a particular Welfare Program, such agreement or contract will be deemed part of the Plan and incorporated herein by this reference.

(b) The Employer will have the right to enter into a contract with one or more Insurance Company (or Companies) for the purposes of providing any benefits under the Plan and to replace any of such Insurance Company (or Companies) or contracts. Any dividends, medical loss ratio rebates, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract will not be assets of the Plan but will be the property of, and will be retained by, the Employer to the extent such amounts are not attributable to Participant contributions. In the event that amounts are attributable to Participant contributions, the Administrator will make a reasonable determination as to how to apply such refunds. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation will include, but not be limited to, losses or obligations which pertain to the following:

(i) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer.

(ii) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure.

(iii) The Employer will not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if the benefits available under this Plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Participant will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this Plan are not enough to provide for an insurance premium but will not be liable for any failure to make such notification.

(iv) When a Covered Employee's employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

Section 6.02 Benefits Supported Only by Welfare Program. Any person having any claim under a Welfare Program will look solely to the assets of the Welfare Program, if any, for satisfaction. In no event will the Employer, any officers or agents thereof, or the Administrator (or other governing body) be liable to any person under the provisions of the Welfare Program.

Section 6.03 Rights of Participants. No Participant will have any right to any amount credited to their Account at any time, except the right to have such credits applied toward the cost of coverage for their Benefit Program elections.

ARTICLE VII
HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of their Compensation to a Health Flexible Spending Account on a pre-tax basis. The amounts contributed to the Health Flexible Spending Account are then used to reimburse the Participant for Medical Care Expenses. The Health Flexible Spending Account is intended to be a self-insured medical reimbursement plan within the meaning of Section 105(h) of the Code and a flexible spending arrangement within the meaning of Proposed Regulation Section 1.125-5 or successive guidance. The Company and the Administrator will take whatever steps necessary to maintain and operate the Health Flexible Spending Account in accordance with the nondiscrimination requirements of Sections 105(h) and 125 of the Code.

Section 7.02 Contributions. The minimum and maximum amounts a Participant may elect to contribute to a Health Flexible Spending Account will be determined by the Company each year and communicated to Participants in writing in the Annual Enrollment materials. In no event shall

the maximum contribution exceed two thousand seven hundred and fifty dollars ($2,750) per year, as indexed for inflation, pursuant to Section 125(i) of the Code. Unless an exception applies as described in Section V, any such election under a Health Flexible Spending Account is irrevocable for the duration of the Plan Year to which it relates.

Section 7.03 General Health Care Spending Account. The Plan Administrator shall establish a bookkeeping account for each Participant who elects to participate in the Health Flexible Spending Account. The total amount elected by the Participant shall be available at all times during the Plan Year for Medical Care Expenses incurred by the Participant.

Section 7.04 Limited Purpose/Post-Deductible Health Care Spending Account. Participants who elect to contribute to a Health Savings Account and a Health Flexible Spending Account, may only be reimbursed for Medical Care Expenses that are not covered under the medical Welfare Program until the Participant has reached the applicable high deductible Medical Program annual deductible. Medical Care Expenses incurred by a Participant that are not covered under the Medical Program such as dental expenses, vision expenses may be reimbursed prior to reaching the Medical Program annual deductible.

Section 7.05 Benefits After Termination and Reinstatement After Return.

(a) A Participant in the Health Flexible Spending Account who terminates employment and who does not elect continuation coverage as provided for herein, will be deemed to have revoked their participation under the Health Flexible Spending Account. Such former Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the former Employee's termination of employment. Continuation coverage shall be administered in accordance with Article XI of this Plan.

(b) A Participant in the Health Flexible Spending Account who goes on a Leave of Absence will be deemed to have continued participation in the Health Flexible Spending Account unless they elect otherwise. In such event, the Participant will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the Participant's Leave of Absence.

(c) In the event an Employee does not have coverage under the Health Flexible Spending Account during FMLA leave (because the Employee chooses to revoke coverage or does not pay the required Employee contributions for any reason during FMLA leave), upon returning from FMLA leave, the Company will reinstate the Employee's Health Flexible Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) Reinstate their per-pay period deduction under the Health Flexible Spending Account, in which case the Participant's elected annual Participant contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) Resume Participant contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Health Flexible Spending Account

will be adjusted to an amount equal to the annual Participant contributions less the actual Participant contributions, divided by the number of pay periods remaining in the Plan Year. Notwithstanding the preceding provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant contributions that will be paid for the Plan Year, the Company may not require the Participant to pay any more than the remaining Participant contributions due.

(iii) Any change in an election that decreases contributions to the Health Flexible Spending Account shall not be less than the total amount of reimbursements made during the entire coverage period.

In no event will reimbursements be permitted for any otherwise eligible Medical Care Expenses during such Leave of Absence.

(d) If the Health Flexible Spending Account coverage continues during the FMLA leave, the Participant's contributions will continue as though they are not on a Leave of Absence.

Section 7.06 Medical Care Expenses. Each Participant will be entitled to reimbursement from their Health Flexible Spending Account for those health care expenses incurred during a Plan Year that are Medical Care Expenses.

Section 7.07 Claim and Payment Procedures. The entire amount a Participant elects to contribute to their Health Flexible Spending Account for the year, less any reimbursements made from the Health Flexible Spending Account for the year, will be available at all times during the period of coverage regardless of the actual amount contributed. A Participant must file claims for reimbursement of Medical Care Expenses from their Health Flexible Spending Account to the Claims Administrator in the manner prescribed by the Claims Administrator. Properly submitted claims will be paid when the total amount of the claims submitted is at least the minimum amount specified by the Administrator. Claims will be honored only if:

(a) Incurred for Medical Care Expenses of the Participant or their Tax Code Dependent;

(b) Incurred for treatment rendered while the recipient was covered by the Health Flexible Spending Account;

(c) Substantiated by (1) a written statement from an independent third party (such as the service provider) stating that the expense was incurred, identifying the treatment or service provided, the date of the service, and the amount of the expense; and (2) a written statement from the Participant that the expense has not been reimbursed and is not reimbursable from any other source of coverage. If an explanation of benefits ("EOB") is submitted, indicating the date of the service and the amount the Participant is responsible to pay for the Medical Care Expenses, together with the statements described above, the claim will be deemed fully substantiated.

(d) With respect to Medical Care Expenses paid through an electronic payment card (e.g., debit card, credit card or similar arrangement), the Participant complies with substantiation procedures established by the Administrator in accordance with applicable federal law.

For this purpose, a Participant or Tax Code Dependent has incurred a Medical Care Expense when they receive the medical care that gives rise to the Medical Care Expense, regardless of when the Participant or their Tax Code Dependent is formally billed or charged for or pays the Medical Care Expense.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the medical care services, treatment or supplies, unless such payment is made through an electronic payment card, as described in subparagraph (d) in this Section.

Section 7.08 Debit Cards. Participants may, subject to the procedure established by the Claims Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards provided by the Claims Administrator and the Plan for payment of Medical Care Expenses, subject to the following terms:

(a) Each Participant issued a card shall certify that such card shall only be used for Medical Care Expenses. The Participant shall also certify that any Medical Care Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) Such card shall be issued upon the Participant's effective date of Participation and reissued for each Plan Year the Participant elects to enroll in the Health Flexible Spending Account. Such card shall be automatically canceled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year up to the maximum amount allowed by the Plan.

(d) The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

(e) The cards shall only be used for Health Care Expense purchases at these providers, including, but not limited to, the following:

(i) Copayments for doctor and other medical care;

(ii) Purchase of drugs;

(iii) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) Such purchases with the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) If such purchase is later determined by the Administrator to not qualify as a Health Care Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(i) Repayment of the improper amount by the Participant;

(ii) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(iii) Claims substitution or offset of future claims until the amount is repaid; and

(iv) If subsections (i) through (iii) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

Section 7.09 Forfeitures of Health Flexible Spending Accounts; Use It or Lose It Rule.

(a) Forfeitures. The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year, excluding any carryover) shall be forfeited and credited to the Health FSA Program surplus. In such event, the Participant shall have no further claim to such amount for any reason.

(b) Use It or Lose It Rule and $550 Carryover. Claims received by the Administrator for expenses incurred after the end of a Plan Year are not eligible for reimbursement under the Plan. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in their Health Flexible Spending Account after all timely submitted claims have been processed. However, if a balance remains after the expiration of the period for submitting claims for one Plan Year, an amount between ten dollars ($10) and five hundred and fifty dollars ($550) of such balance will be carried forward into the succeeding Plan Year.

(c) Special Circumstances. The Plan Administrator may allow Account balances to rollover to the following Plan Year, in its sole discretion if otherwise permitted by and in accordance with IRS or Department of Labor temporary or permanent guidance.

(d) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Health Flexible Spending Accounts for any particular Plan Year and will apply such forfeitures, insofar as possible to the reasonable expenses of maintaining and administering the Plan. Forfeitures shall be administered in accordance with the ERISA “plan asset” rules, to the extent applicable. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Welfare Program benefit available under the Plan (except any allowed carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by the Code.

Section 7.10 Unclaimed Benefits. Any benefit payments remaining unclaimed (e.g., uncashed checks) for more than one year after issuance of the corresponding reimbursement check will be forfeited and the forfeited amounts will be returned to the Company to the extent permitted by law.

Section 7.11 Statements. The Administrator will issue to each Participant in writing at the conclusion of each Plan Year a statement describing the total credit to their Health Flexible Spending Account for such Plan Year and the type and amount of debits from their Health Flexible Spending Account for such Plan Year.

Section 7.12 Qualified Reservist Distributions. A Qualified Reservist Distribution (QRD) may be made if the Participant provides the Administrator with a copy of the order or call to active duty and the Administrator determines that the order or call is for a period of active duty of one hundred and eighty (180) days or more or is indefinite. If the period specified is less than one hundred and eighty (180) days, a QRD will not be permitted unless subsequent calls or orders increase the total period of active duty to 180 days or more. A QRD may be made in the amount contributed to the Health Flexible Spending Account as of the date of the QRD request, minus reimbursements paid as of the date of the QRD request. Additional claims may not be submitted for Medical Care Expenses incurred after the date a QRD is requested. The Administrator will pay the QRD to the Participant within a reasonable time, but not more than sixty (60) days after the request for the QRD has been made. A QRD may not be made with respect to a Plan Year ending before the order or call to active duty.

ARTICLE VIII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Section 8.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of their Compensation to a Dependent Care Flexible Spending Account on a pre-tax basis. The amount contributed to the Dependent Care Flexible Spending Account is used to reimburse the Participant for Dependent Care Expenses as defined in Section VIII.04. The dependent care spending account is intended to be a "dependent care assistance program" within the meaning of code section 129, and a flexible spending arrangement within the meaning of proposed regulation section 1.125-5 of successive guidance. The company and the administrator will take whatever steps necessary to maintain and operate the Dependent Care Flexible Spending Account in accordance with the nondiscrimination requirements of sections 129 and 125 of the code.

Section 8.02 Maximum Contribution. The maximum amount a Participant can elect to have contributed to their Dependent Care Flexible Spending Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such amount exceed the limits set forth in Section 129 of the Code.

Section 8.03 Benefits During a Leave of Absence or After Termination.

(a) If a Participant ceases to be a Participant in this Dependent Care Flexible Spending Account for any reason during a Plan Year, the Participant's election to contribute to the Dependent Care Flexible Spending Account will terminate. The Participant will be entitled to reimbursement

only for Dependent Care Expenses incurred within the same Plan Year prior to termination of employment, and only if the Participant applies for such reimbursement in accordance with Section 8.05. No such reimbursement will exceed the remaining balance, if any, in the Participant's Dependent Care Flexible Spending Account for the Plan Year in which the expenses were incurred. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Section.

(b) In the event a Participant does not have coverage under the Dependent Care Flexible Spending Account during a Leave of Absence (because the Participant chooses to revoke coverage or does not pay the required Participant contributions for any reason during such Leave of Absence), upon returning from such Leave of Absence within the same Plan Year as such Leave of Absence began, the Employer will reinstate the Participant's Dependent Care Flexible Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) Reinstate their per-pay period deduction under the Dependent Care Flexible Spending Account, in which case the Participant's elected annual Participant contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) Resume Participant contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Dependent Care Flexible Spending Account will be adjusted to an amount equal to the annual Participant contributions less the actual Participant contributions, divided by the number of pay periods remaining in the Plan Year. Notwithstanding the provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant contributions that will be paid for the Plan Year, the Employer may not require the Employee to pay any more than the remaining Participant contributions due.

In no event will reimbursements be permitted for any otherwise eligible expenses incurred during such Leave of Absence.

(c) If the Dependent Care Flexible Spending Account coverage continues during a Participant's Leave of Absence, the Participant's contributions will continue as though they are not on a Leave of Absence.

Section 8.04 Dependent Care Expenses. Each Participant will be entitled to reimbursement from their Dependent Care Flexible Spending Account for those Dependent Care Expenses incurred during a Plan Year.

Section 8.05 Earned Income Limit. For any Plan Year, reimbursement under this Plan for Dependent Care Expenses will not exceed the Participant's earned income limit calculated under the following rules. For purposes of this Section 8.05, "earned income" means the total wages, salary, and other Employee compensation and any net earnings from self-employment for the Plan Year.

(a) In the case of a Participant who is not married at the close of the Plan Year, the limit equals the Participant's earned income.

(b) In the case of a Participant who is married at the close of the Plan Year, the limit equals the lesser of the Participant's earned income or the earned income of the Participant's Spouse.

(c) During any month in the Plan Year, if the Participant's Spouse is either a full-time student at an educational institution or is physically or mentally not able to take care of himself, the Spouse will be deemed to have "earned income" for that month of two hundred and fifty dollars ($250.00) (or four hundred and fifty dollars ($450.00) if there are at least two (2) qualifying individuals (as defined in Section 8.04).

(d) A married Participant who is legally separated or living apart will be considered not married if he or she is treated as not married under the rules of Sections 21(e)(3) and (4) of the Code.

Section 8.06 Claim and Payment Procedures. A Participant must file claims for reimbursement of eligible Dependent Care Expenses from their Dependent Care Flexible Spending Account with the Claims Administrator on the appropriate form furnished by the Claims Administrator, no later than the last day of the Run-Out Period associated with the Plan Year to which the claim relates. The Participant will be required to furnish receipts and statements from the providers of dependent care, but the Participant will complete the provider information section of the claim form and certify that this information is true. All claims submitted by a Participant during a reimbursement period will be processed as of the end of that reimbursement period on the basis of the balance in the Participant's Dependent Care Flexible Spending Account for at the end of such reimbursement period. To the extent that any claims cannot be paid in full because credit in the Participant's Dependent Care Flexible Spending Account is insufficient to cover the claim, the claim will be held for payment in the next succeeding reimbursement period(s) of such Plan Year, but will not be carried over or charged against the balance of any subsequent Plan Year. Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the dependent care.

Section 8.07 Forfeitures of Dependent Care Flexible Spending Account; Use It or Lose It Rule.

(a) Use It or Lose It Rule. Claims for expenses incurred during a Plan Year must be submitted no later than the last day of the Run-Out Period associated with such Plan Year. Claims received by the Administrator following the close of the Run-Out Period for expenses incurred during the previous Plan Year will be untimely and not eligible for reimbursement under the Plan. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in their Dependent Care Flexible Spending Account after all timely claims have been processed. Similarly, no balance remaining after the expiration of the Run-Out Period for one Plan Year will be carried forward into any succeeding Plan Year.

(b) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Dependent Care Flexible Spending Accounts for any particular Plan Year, and will apply such forfeitures, insofar as possible to the reasonable expenses of maintaining and administering the Plan.

(c) Unclaimed Benefits. Any benefit payments remaining unclaimed (e.g. uncashed checks) for more than one (1) year after issuance of the corresponding reimbursement check will be forfeited and the forfeited amounts will be returned to the Company to the extent permitted by law.

Section 8.08 Statements. The Administrator will issue to each Participant in writing at the conclusion of each Plan Year a statement describing the total credits to their Dependent Care Flexible Spending Account for such Plan Year and the type and amount of debits for such Plan Year.

ARTICLE IX
SPECIAL COVERAGE PROVISIONS

Section 9.01 Applicability. This Article IX will only apply to Welfare Programs that would be considered a "group health plan" under Section 5000(b)(1) of the Code.

Section 9.02 COBRA Continuation Coverage.

The Continuation of Coverage provisions of this Plan shall be interpreted in a manner that is consistent with COBRA and shall be limited to the minimum length and type of coverage, if any, that is required by COBRA.

(a) For purposes of this Section 9.02 only, the following terms have the following meanings:

(i) "*Continuation Coverage*" means coverage under the Group Health Welfare Programs which, as of the time coverage is being provided, is identical to the coverage provided under the Group Health Welfare Program immediately prior to the Qualifying Event to similarly situated beneficiaries with respect to whom a Qualifying Event has not occurred. Notwithstanding the previous sentence, if coverage under the Group Health Welfare Program is modified for all similarly situated Covered Persons, it shall be modified for all persons who have elected Continuation Coverage hereunder.

(ii) "*Qualified Beneficiary*" means a Covered Person who experiences a "Qualifying Event." Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

(iii) "*Qualifying Event*" means, with respect to any Covered Person, any of the following events which, but for the Continuation Coverage required under this Section 8.02, would result in the loss of coverage of a Qualified Beneficiary:

(A) The death of the Covered Employee;

(B) The termination (other than by reason of gross misconduct), or reduction of hours, of the Covered Employee's employment with the Employer;

(C) The divorce, or legal separation of the Covered Employee from their Spouse;

(D) The Covered Person becoming entitled to Medicare;

(E) A Dependent child ceasing to be an eligible Dependent;

(iv) "*Election Period*" means a period beginning on the date coverage terminates as a result of a Qualifying Event and ending sixty (60) days after the later of:

(A) The date coverage terminates under the Group Health Welfare Program.

(B) The date the Qualified Beneficiary receives notice from the Employer or Plan Administrator informing them of their right to elect COBRA continuation coverage; or

(C) Any other date or time period mandated by the Department of Labor and/or the Internal Revenue Service.

(b) Right to Elect Continuation of Coverage. Each "Qualified Beneficiary" who would lose coverage under the Group Health Welfare Programs as a result of a Qualifying Event shall be entitled to elect, within the Election Period, Continuation Coverage under the Group Health Welfare Program. An election by a Covered Person is considered an election on behalf of all related Qualified Beneficiaries unless such Qualified Beneficiary makes an individual election. If there is a choice among types of coverage, each Qualified Beneficiary is entitled to make a separate selection among such types of eligible coverage.

(c) Period of Coverage and Notice Requirement.

(i) In the case of a Qualifying Event which occurs as a result of the termination or reduction in hours of a Covered Employee's employment, the Continuation Coverage, if elected, may continue up to the date which is eighteen (18) months after the date of the Qualifying Event (the "**Initial COBRA Period**");

(ii) If a Qualifying Event results from a Covered Employee's termination or reduction in hours of employment and a Qualified Beneficiary with respect to such Qualifying Event is disabled under Title II or XVI of the Social Security Act at any time prior to the sixtieth (60^{th}) day of the initial COBRA period, coverage may be extended up to the earlier of: (A) twenty-nine (29) months, or (B) thirty (30) days following the date the Social Security Administration determines the Qualified Beneficiary is no longer disabled, provided that the Qualified Beneficiary

notifies the Group Health Welfare Program Administrator of the determination of the Qualified Beneficiary's disability within sixty (60) days of the latest of:

(A) The date Social Security Administration issues the disability determination;

(B) The date the qualifying event occurs; or

(C) The date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event.

The Qualified Beneficiary must provide notice to the Group Health Welfare Program Administrator within thirty (30) days of the date the Social Security Administration determines they are no longer disabled.

(iii) In the event that a Qualifying Event occurs from termination or reduction in hours of a Covered Person's employment, and a second Qualifying Event occurs during the eighteen (18) or twenty nine (29) month period of Continuation Coverage, then the Continuation Coverage, if elected, may be continued, the period of coverage with respect to such events shall not exceed a total of thirty-six (36) months beginning from the date of the first Qualifying Event provided the Qualified Beneficiary provides notice to the Group Health Welfare Program Administrator within sixty (60) days of the second Qualifying Event.

(iv) In the case of a loss of coverage which occurs as a result of the death, divorce or legal separation of the Covered Employee, the Covered Person's entitlement to Medicare benefits, or an Eligible Dependent child ceasing to be an Eligible Dependent, the Continuation Coverage, if elected, may continue up to the date which is thirty six (36) months after the date of the Qualifying Event, provided that the Qualified Beneficiary provides notice to the Group Health Welfare Program Administrator within sixty (60) days of the Qualifying Event.

(v) In the event that a Qualifying Event occurs from the termination of employment or reduction in hours of a Covered Employee's employment less than eighteen (18) months after the Covered Person becomes entitled to Medicare coverage, Qualified Beneficiaries who have elected Continuation Coverage may continue their coverage for up to thirty six (36) months from the date of the Covered Person's entitlement to Medicare coverage.

(d) Continuation Coverage will cease on the earliest of the following dates:

(i) The date Continuation Coverage ceases in accordance with paragraphs 9.02(c) (i), (ii), (iii), (iv), or (v) above, as applicable;

(ii) The date on which the Employer ceases to provide any group health plan to any employee;

(iii) The date on which there is a failure to make timely payment (including a grace period of thirty (30) days after the payment due date or a period of forty five (45) days if

payment is made in connection with the initial election after the Qualifying Event) of any premium with respect to the Qualified Beneficiary;

(iv) The date on which the Qualified Beneficiary first becomes (after the date of election):

(A) Covered under any other group health plan (as an employee or otherwise), except that Continuation Coverage will not cease if the other group health plan under which the Qualified Beneficiary becomes covered contains any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary which applies to (or is not satisfied by) such Qualified Beneficiary despite Part 7 of Title I of ERISA;

(B) Entitled to Medicare benefits; or

(C) In the case of a Qualified Beneficiary who is receiving Continuation Coverage for more than eighteen (18) months due to their disability, thirty (30) days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

(e) Premium Requirement.

(i) The premium cost for any period of Continuation Coverage, except as set forth in (ii), below, shall be one hundred and two percent (102%) of the cost to the Group Health Welfare Program for such period as determined in accordance with reasonable actuarial standards consistently applied. If the premium cost is modified for any similarly situated Covered Person, it may be modified for all persons who have elected Continuation Coverage hereunder. The Covered Person, if such Covered Person so elects, may make monthly installment payments of such premium cost.

(ii) In the event that coverage is continued for more than eighteen (18) months because of a disability extension, the premium cost for any month after the eighteenth (18th) month of Continuation Coverage may be increased to one hundred and fifty percent (150%) of the cost to the Group Health Welfare Program for such period.

(f) Notice Requirements

(i) *General Rules for Notice by the Plan Administrator*. Any notice that is provided by the Group Health Welfare Program Claims Administrator may be furnished to a Covered Employee and the Covered Employee Dependents by furnishing a single notice addressed to both the Covered Person and the Dependent if, on the basis of the most recent information available to the Plan the Dependents resides at the same location as the Covered Employee. Any notice that is provided by the Plan Administrator may be furnished by in-hand delivery, first class mail, or any other method that is consistent with Department of Labor Regulation Section 2520.104b-1. Therefore, in appropriate cases, delivery may be made through electronic media.

(ii) *Initial Notice*. The Group Health Welfare Program Administrator shall furnish written notice of the rights provided by this Section 9.02 to each Covered Person and their

Eligible Dependents not later than the earlier of (A) ninety (90) days after the date on which such individual's coverage under the Group Health Welfare Program commences, or (B) the first date on which the Plan Administrator is required to furnish the Qualified Beneficiary with notice of the right to elect Continuation Coverage pursuant to Paragraph (iii) below.

(iii) *Election Notice*. The Plan Administrator shall furnish written notice of the rights provided by this Section 9.02 to any Qualified Beneficiary no later than fourteen (14) days following the date the Plan Administrator receives notification from the Employer of a Qualifying Event which results from the Covered Employee's death, termination of employment, reduction in hours of employment, or Medicare eligibility. The Employer must notify the Plan Administrator of such Qualifying Event within thirty (30) days of its occurrence.

(iv) *Election Notice Following Notice from Qualified Beneficiary*. If the Group Plan Administrator receives notice from a Qualified Beneficiary within sixty (60) days of the death, divorce or legal separation of the Covered Employee, the Covered Person's entitlement to Medicare benefits, or an eligible Dependent child ceasing to be an eligible Dependent, the Plan Administrator shall provide written notice of the rights provided by this Section 9.02 to any Qualified Beneficiary no later than fourteen (14) days following the date the Group Health Welfare Program Administrator is notified of such Qualifying Event.

(v) *Notice of Unavailability of Continuation Coverage*. If the Group Health Welfare Program Administrator receives a notice furnished in accordance this Section 9.02 and determines that the individual is not entitled to Continuation Coverage, Plan Administrator shall provide to such individual a written explanation as to why the individual is not entitled to Continuation Coverage. Such explanation shall be written in a manner calculated to be understood by the average Covered Person and shall be furnished by the Plan Administrator no later than fourteen (14) days following the date the Plan Administrator receives such a notice from the individual.

(vi) *Notice of Termination of Continuation Coverage*. If the Continuation Coverage that is being provided to a Qualified Beneficiary terminates before the end of the applicable maximum coverage period set forth in 9.02(d), the Plan Administrator shall provide written notice of the termination of Continuation Coverage to the Qualified Beneficiary in a manner calculated to be understood by the average Participant. Such notice shall include the reason that Continuation Coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event, the date of termination of Continuation Coverage, and any rights the Qualified Beneficiary may have under the Group Health Welfare Program or under applicable law to elect an alternative group or individual coverage, such as a conversion right. Such notice shall be furnished by the Plan Administrator as soon as practicable following the Plan Administrator's determination that Continuation Coverage shall terminate.

(vii) General Rules for Notices and Elections by Qualified Beneficiaries.

(A) <u>Electing Continuation Coverage</u>. A Qualified Beneficiary must make an affirmative election to continue coverage under the Group Health Welfare Program with the Election Period. If no such election is made within the Election Period, Continuation Coverage

shall not be available and the Qualified Beneficiary's coverage under this Group Health Welfare Program.

(B) Notice and Election Procedures. Each notice or election to be provided by a Covered Person or a Qualified Beneficiary under this Subsection (f) must comply with the procedures established by the Group Health Welfare Program Administrator. Such procedures shall be described in the summary plan description of the Group Health Welfare Program, specify the individual or entity designated to receive such notices or elections, specify the means by which the notice or election may be furnished, and describe the information concerning the Qualifying Event or determination of disability the Group Health Welfare Program deems necessary in order to provide Continuation Coverage rights. Such information must be sufficient to enable the Plan Administrator to determine the Group Health Welfare Program, the Covered Person, the Qualified Beneficiaries, the Qualifying Event or disability determination, and the date on which the Qualifying Event or disability determination occurred. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

Section 9.03 Trade Act Eligible Individuals.

(a) *COBRA Election*. If Continuation Coverage is not elected during the Election Period by a Trade Act Eligible Individual, such individual may elect Continuation Coverage during the sixty (60) day period that begins on the first day of the month in which the individual becomes a Trade Act Eligible Individual, but only if such election is made not later than six (6) months after the date of the Trade Act Loss of Coverage in accordance with the procedures described in Section 9.02 above.

(b) *Commencement of Coverage*. Any Continuation Coverage elected by a Trade Act Eligible Individual under Paragraph (a) shall commence at the beginning of the sixty (60) day election period described in such paragraph and shall not include any period prior thereto.

(c) *Trade Act Eligible Individual*. The term "Trade Act Eligible Individual" means, with respect to any month, any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. The term "Trade Act Eligible Individual" also means, with respect to any month, any individual who is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and is receiving a benefit for such month under section 246(a)(2) of such Act. An individual shall continue to be treated as a Trade Act Eligible Individual during the first month that such individual would otherwise cease to be a Trade Act Eligible Individual by reason of the preceding provisions of this paragraph.

(d) *Trade Act Loss of Coverage.* The term "Trade Act Loss of Coverage" means, with respect to an individual whose separation from employment gives rise to being a Trade Act Eligible Individual, the loss of Group Health Welfare Program coverage associated with such separation.

(e) *Consistency with Regulations*. The Continuation of Coverage provisions of this Plan shall be interpreted in a manner that is consistent with COBRA, and shall be limited to the minimum length and type of coverage, if any, that is required by COBRA.

Section 9.04 Other Continuation Coverage. Under the requirements of USERRA and FMLA, the Administrator shall offer to continue Welfare Program coverage providing group health plan benefits to certain Covered Persons. A Covered Person who would otherwise lose group health plan coverage as a result of a leave of absence under USERRA or the FMLA will be entitled to continue such coverage under the Welfare Program as provided by USERRA or the FMLA, as applicable. The coverage will be identical to the coverage provided to persons who are Actively at Work. Additionally, continuation of coverage will also be made available as required by applicable state or local law.

Section 9.05 Compliance with Federal Mandates. Notwithstanding anything contained in any Program Document to the contrary, the following provisions will apply to each Group Health Program as applicable or required:

(a) Minimum Hospital Stay. The Plan will comply with the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time.

(b) Mental Health Benefits. The Plan will comply with the MHPAEA, to the extent MHPAEA is applicable to the Plan.

(c) Benefits for Reconstructive Surgery Following Mastectomy. The Plan will comply with the Women's Health and Cancer Rights Act of 1998, as amended from time to time.

(d) Affordable Care Act. The Plan will comply with the applicable requirements of the Affordable Care Act, as such requirements become effective from time to time with respect to the Plan. The Employer's requirement to offer certain medical benefits to avoid tax penalties under Code Section 4980H is set forth in Appendix C.

(e) Genetic Information. The Plan will comply with the applicable requirements of the Genetic Information Nondiscrimination Act of 2008, as such requirements become effective from time to time with respect to the Plan.

(f) No Surprises Act. The Plan will comply with the applicable requirements of the No Surprises Act of 2022.

(g) Other Laws. The Plan intends to comply with all other Federal laws applicable to the Plan, however, the Company reserves the right not to adopt or implement any provision that gives the Company discretion as to adoption or implementation of such Federal law. This Section 9.05 will not create any rights in excess of the minimum required by law.

ARTICLE X
COORDINATION OF BENEFITS
AND RECOVERY OF BENEFIT OVERPAYMENT

Section 10.01 Coordination of Benefits. Except as specifically provided otherwise in an applicable Program Document, this Section will apply to the coordination of benefits with respect to any medical or health benefit.

(a) General. The rules set forth in this Section 10.01 coordinate the payment of benefits under the Plan with other group health plans under which a Participant or covered Dependent is covered so that the Participant or covered Dependent receives all of the benefits to which he or she is entitled, but not to exceed 100% of total allowable expenses under this Plan. When a claim is made, the order of benefit determination rules set forth below determine whether the Plan is a "primary plan" or a "secondary plan." When the Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When the Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits. No plan pays more than it would without the coordination provision.

(b) Definitions. For purposes of this Section, the following definitions will apply:

(i) An "*allowable expense*" means any necessary, reasonable health care service or expense, including deductibles and copayments, covered, at least in part, by any of the other group health plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service, or a portion thereof, that is not covered by any of the plans is not an allowable expense.

(ii) "*Other group health plans*" means the following types of medical, dental, and vision care benefits:

(A) Coverage under a governmental program or provided or required by law, except a state Medicaid plan under Title XIX of the Social Security Act;

(B) Group insurance or group-type coverage, whether insured or uninsured. This includes group or group type coverage under health maintenance organizations and other pre-payment, group practice or individual practice coverage;

(C) Group-type contracts that are contracts not available to the general public and that can be obtained and maintained only because of membership in or in connection with a particular organization or group; and

(D) Health benefits coverage under group, homeowners, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

Each contract or other arrangement is a separate group health plan. If an arrangement has two parts and the coordination of benefit rules apply only to one of the two, each of the parts is a separate group health plan.

(c) Order of Benefit Determination Rules. When two (2) or more plans pay benefits, a plan without a coordinating provision is always the primary plan. If all plans have such a provision,

the first of the following rules that describes which plan is primary will determine the order of payment:

(i) Non-Dependent or Dependent. The plan under which the individual is the eligible individual (rather than a covered Dependent) is primary and the other is secondary unless such person is a Medicare beneficiary.

(ii) Child of Parents Not Separated or Divorced. If a covered Child is covered under both parents' plans, the birthdays of the covered Child's parents are used to determine which plan is primary. The plan of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be primary. If both parents have the same birthday, then the plan that has had coverage in effect for the covered Dependent child for the longest period of time is primary.

(iii) Child of Parents Separated or Divorced. If the parents are separated or divorced and a court order makes one parent responsible for the Child's health care, the plan of that parent is primary. If there is no court order, the following will apply:

(A) The plan of the parent with custody is primary;

(B) The plan of the person married to the parent with custody (step-parent) is secondary; and

(C) The plan of the parent without custody pays third.

If neither paragraphs (i), (ii) or (iii) applies, the plan covering the individual for the longest period of time is primary.

(iv) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that person's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(v) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, or subscriber (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(vi) Longer or Shorter Length of Coverage. The plan that covered the person longer is primary.

(vii) Other Rules Do Not Apply. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

(d) Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and other plans. A Participant or covered Dependent will give information about coverage under any other plans under which such individual is covered when he or she submits a claim for benefits under a Welfare Program. The Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Administrator need not tell, or get the consent of, any person to do this.

(e) Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(f) Right of Recovery. If the amount of the payments made by the Administrator is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 10.02 Medicare-Eligible Active Employees and Their Dependents. This Section will only apply to "medical benefits" (within the meaning of Medicare) provided under the Welfare Programs for Eligible Employees who are Actively at Work.

(a) Each Medicare-eligible Participant covered by a Welfare Program providing medical benefits will continue to be covered by such Welfare Program, and this Plan will pay primary.

(b) Each Medicare-eligible Dependent of an Employee covered by a Welfare Program providing medical benefits shall continue to be covered by such Welfare Program, and this Plan will pay primary

(c) Notwithstanding anything in subsections (a) or (b) to the contrary, Medicare will be the primary coverage for a Medicare-eligible Participant in accordance with Section 1862 of the Social Security Act, as it relates to individuals with end-stage renal disease.

Section 10.03 Subrogation, Reimbursement and Recovery for Third Party Liability. As a condition for receiving benefits under the Plan, each Covered Person agrees to and grants the Plan the right to subrogation, the right to reimbursement, and the right of recovery as set forth herein. When a Covered Person becomes sick or injured as a result of the act or omission of another person or party and the Covered Person received benefits under the Plan for such injuries, the Covered Person must reimburse the Plan for benefits received from all recoveries from a third party (whether by lawsuit, settlement or otherwise) and the Plan's share of the recovery will not be

reduced because the Covered Person has not received the full damages for the claims, unless the Plan agrees, in writing, to such a reduction. If the Covered Person breaches this third party reimbursement provision, then the Covered Person agrees to indemnify the Plan for all costs of recovering third party reimbursements. To the extent that any Program Document also contains provisions regarding subrogation, reimbursement, or right to recovery of expenses, this Section 10.03 and the applicable Program Document will both apply so as to grant the Plan the greatest possible rights with respect to subrogation, reimbursement, and recovery of such expenses or benefits. Except as specifically provided otherwise in an applicable Program Document, this Section 10.03 will apply to any health or disability benefit provided through the Welfare Programs.

(a) Right of Subrogation. As a condition to participation in or the receipt of benefits under the Plan, each Covered Person agrees that the Plan will have the right of subrogation with respect to the full amount of benefits paid to or on behalf of a Covered Person as the result of an injury, illness, disability or death that is or may be the responsibility of any Third Party. The Plan will also have a lien upon any recovery from such Third Party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole. Regardless of how such claims or recoveries are classified or characterized by the parties, the courts or any other entity, such classification shall not impact the covered individual's responsibilities described above or the Plan's entitlement to first-dollar recovery, regardless of whether the covered individual is made whole.

(b) Reimbursement Agreement. If a Covered Person incurs expenses that are excluded in accordance with this provision of the Plan because they are or may be the responsibility of a Third Party, the Covered Person will be required, as a prerequisite to receiving Plan benefits, to sign a reimbursement agreement in a form acceptable to the Administrator acknowledging the Covered Person's obligation to reimburse the Plan for any benefits or expenses paid by the Plan from the first dollars recovered from any source. If expenses are incurred by a minor, the Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Administrator may, in its sole discretion, withhold benefit payments that might otherwise be advanced, and/or initiate an action at law or in equity in its own name or in the name of the Covered Person, in order to enforce, secure, or protect the Plan's rights under this provision. If the Covered Person elects not to execute such an agreement, the Plan is not obligated to provide any benefit payments.

(c) Right of Reimbursement. Whether or not a Covered Person executes a reimbursement agreement, in the event that the Plan provides benefits to a Covered Person and the Covered Person recovers a payment, either by settlement, judgment, no-fault automobile insurance statute, homeowners insurance, or otherwise, from any Third Party or other source, then the Covered Person will immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for health expenses, such as pain and suffering, the Covered Person will still be required to reimburse the Plan first. The Plan will have a lien upon any such recovery in the

amount of benefits or expenses paid by the Plan. The Plan's right of reimbursement will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole.

(d) Procedures for Subrogation and Reimbursement. Each Covered Person or his or her legal representative must do whatever is requested by the Administrator with respect to the exercise of the subrogation and reimbursement rights of the Welfare Program and the Employers and will do nothing to prejudice those rights. In addition, each Covered Person or his or her legal representative, in conjunction with making a claim for Welfare Program benefits, must inform the Administrator in writing whether the Covered Person was injured by a Third Party, and must provide the following information in a timely, prompt fashion as a condition to receipt of Welfare Program benefits:

(i) The name, address, and telephone number of the Third Party that in any way caused the injury, illness or disability, and of the attorney representing the Third Party;

(ii) The name, address, and telephone number of the Third Party's insurer and any insurer of the Covered Person;

(iii) The name, address, and telephone number of the Covered Person's attorney with respect to the Third Party's act;

(iv) Prior to the meeting, the date, time and location of any meeting between the Third Party or their attorney and the Covered Person, or their attorney;

(v) All terms of any settlement offer made by the Third Party or their insurer or the Covered Person's insurer;

(vi) All information discovered by the Covered Person, or their attorney, concerning the insurance coverage of the Third Party;

(vii) The amount and location of any funds that are recovered by the Covered Person from the Third Party or his or her insurer or the Covered Person's insurer, and the date that the funds were received;

(viii) Prior to settlement, all information related to any oral or written settlement agreement between the Covered Person and the Third Party or their insurer or the Covered Person's insurer;

(ix) All information regarding any legal action that has been brought on behalf of a Covered Person against the Third Party or their insurer; and

(x) All other information requested by the Administrator.

No Covered Person (or the person's legal representative) may retain an attorney with respect to the Third Party without the prior written consent of the Administrator. As

a condition of receiving benefits under the Welfare Program, each Covered Person (and that person's legal representatives) hereby:

(xi) Waives the assertion of any attorney-client privilege against an Employer with regard to an attorney retained by the Covered Person;

(xii) Agrees that an Employer may assume, at its discretion, the defense of any action that has been or could be brought against the Third Party by the Covered Person (or that person's legal representatives);

(xiii) Agrees that an Employer must be given the opportunity to approve any settlements before they are made with the Third Party;

(xiv) Agrees to consent to judgment for the Plan;

(xv) Agrees not to assert a defense under Section 502 of ERISA to a claim made by the Plan; and

(xvi) Agrees that a claim brought by the Plan to enforce its rights under this Section 10.03 is an equitable claim.

Any funds recovered by a Covered Person (or that person's legal representative) from a Third Party (or the Third Party's insurer) must and are deemed to be held in constructive trust for the benefit of the Welfare Program and the Employer to the extent of the amount of Welfare Program benefits until reimbursement, with the Covered Person (or that person's legal representative) as trustee and fiduciary.

(e) Coverage for Expenses Caused by a Third Party. The Administrator may, in its sole discretion, cease to pay benefits under a Welfare Program if a Covered Person refuses to execute a reimbursement agreement. The Administrator may cease to pay benefits subject to a reimbursement agreement if, in the discretion of the Administrator, the Covered Person has failed or is failing to fulfill his or her duty to cooperate or to comply with the provisions of this Section 10.03.

(f) Right of Recovery and Offset. The Plan will have the right to recover any benefits paid to a Covered Person or his or her health care provider that a Covered Person fails to reimburse to the Plan under the provisions of this Section 10.03. To the extent not otherwise paid to the Plan, the amount due to the Plan will reduce any other present or future benefits payable from the Plan to or on behalf of the Participant. In addition, the Administrator may, in its sole discretion, employ any other lawful means to recover overpayment on behalf of the Plan. These rights are in addition to any other rights and remedies that the Plan may have.

(g) Attorneys' Fees and Expenses. The Welfare Program's right, and the amount to be reimbursed to the Welfare Program, will equal the amount of benefits the Covered Person received from the Welfare Program, adjusted by the Covered Person's reasonable share of attorneys' fees and costs to obtain payment from the Third Party, but will not exceed the amount the Participant actually received from the Third Party.

Section 10.04 Recovery of Benefit Overpayment. If any benefit from a Welfare Program paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person or other recipient fails to repay the amount promptly, then the overpayment may be recovered by the Administrator to the extent permitted by law from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under any Employer sponsored benefit programs, including the applicable Welfare Program. The Administrator also reserves the right to recover any such overpayment by appropriate legal action.

Section 10.05 Termination of Coverage for False Representations or Fraud. If any individual makes a false representation to, or commits any other fraud under or with respect to, the Plan, the Administrator has the right to permanently terminate coverage for the individual and his or her Dependents to the extent permitted by law. This may include, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible (for example, adding a spouse before the date of marriage or failing to notify the Plan of a divorce from a covered spouse). Any termination of coverage will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation of material fact, the individual's coverage may be terminated by the Administrator on a retroactive basis (a "rescission" of coverage), in which case the individual will receive a notice of the rescission, as required by the Affordable Care Act. To the extent permitted by law, the Administrator may also seek reimbursement from the individual for all claims or expenses paid by the Plan as a result of the false representation or other fraud, and may pursue legal action against the individual.

ARTICLE XI
ADMINISTRATION

Section 11.01 Administration. The Administrator, or its designee, shall have and exercise all power, rights, and duties reserved in the Plan or under applicable law to the Administrator when acting in such capacity. The principal duty of the Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive purposes of providing benefits to the Participants and their beneficiaries and defraying reasonable administrative expenses of the Plan and is operated consistently for similarly situated individuals. Except as otherwise provided by the Plan or any relevant Program Document, the Administrator will be the "named fiduciary" of the Plan, within the meaning of Section 402(a) of ERISA for all Welfare Programs that are subject to ERISA.

Section 11.02 Liability and Indemnification. The Company and any person to whom it may delegate any duty or power in connection with administering the Plan, the Administrator and the officers and directors of the Company, will be entitled to rely conclusively upon, and will be fully protected in any action taken or suffered by them in good faith in the reliance upon, any accountant, counsel, other specialist or other person selected by the Administrator or in reliance upon any tables, valuations, certificates, opinions or reports which will be furnished by any of them. The Administrator (and the individual members thereof) will be indemnified by the Company against any and all liabilities arising by reason of any act or failure to act made in good faith in accordance with the Plan, including expenses reasonably incurred in the defense of any related claim. A Plan

fiduciary that is a third party service provider or an insurer will be entitled to indemnification only to the extent provided in a written agreement with such service provider.

Section 11.03 Powers and Authority of the Administrator. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, unilateral discretion to do the following, in addition to any other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including (i) the establishment of claims review procedures in accordance with Section 503 of ERISA or other applicable law and regulations, (ii) the establishment of QMCSO procedures in accordance with Section 609 of ERISA, and (iii) rules and regulations for the conduct of business by the Administrator;

(b) To interpret the Plan and to determine all questions arising under or in connection with the Plan, including all questions of eligibility to participate and obtain benefits under the Plan, its interpretation thereof in good faith to be final and conclusive on all interested persons. The Administrator has sole discretionary authority to grant or deny benefits under this Plan. Benefits under this Plan will be paid only if the Administrator decides, in its sole discretion, that the Participant is entitled to them; provided, however, that the Administrator may delegate to a claims committee, in accordance with Article XII the right and discretion to make determinations as to claims;

(c) To appoint such agents, counsel, accountants, consultants and other persons (regardless of whether they also provide services to the Company) as may be required to assist in administering the Plan;

(d) To allocate and delegate its responsibilities under the Plan and to designate other persons from time to time to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;

(e) To request of and obtain from any Employee, Employer or the Company such information and records as it deems necessary and proper;

(f) To develop election forms and any other forms necessary for Plan administration; and

(g) To delegate the duty of claims decisions and adjudication to an Insurance Company or third party administrator. Such Insurance Company or third party administrator will be the Claims Administrator under this Plan.

(h) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits by operation of the Plan;

(i) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable sections of the Code;

(j) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(k) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of Benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(l) To amend the Plan, as described in Section 13.01.

All actions and determinations of the Administrator will be final and binding upon all current Employees, former Employees, Participants, Dependents, beneficiaries, Employers, the Company and any other interested parties.

Section 11.04 Designation of Fiduciaries. The Administrator may designate in writing other persons to carry out a specified part or parts of its responsibilities hereunder (including the power to designate other persons to carry out a part of such designated responsibility), but such designation may not include any power to manage or control assets of the Plan and may not include the power to appoint investment managers. In addition, the Administrator has been designated as a fiduciary of the Plan with respect to the review and determination of benefit claims. The Administrator has been delegated all powers and rights provided in Section 11.03. The Administrator has accepted such designation and delegation. The Administrator may designate in writing other persons to carry out a specified part or parts of its responsibilities hereunder (including the power to designate other persons to carry out a part of such designated responsibility).

ARTICLE XII
CLAIMS ADMINISTRATION

Section 12.01 General. All claims for benefits under the Plan will be submitted to and decided by such persons or organizations as the Administrator may from time to time designate, in the form and within the time specified by the Administrator, as set forth in the relevant Program Document. Claims shall be administered in accordance with all relevant law. If a group health Program Document does not provide Claims Procedures, group health program benefits will be determined in accordance with the procedures set forth on Exhibit E attached hereto.

Section 12.02 Delegation of Claims Administration Duties. The Administrator may delegate its authority and responsibilities under this Article to a Claims Administrator, provided such delegation is in writing. Any reference to Administrator in this Article will mean the applicable Claims Administrator if the relevant authority and responsibility has been delegated by the Administrator to that Claims Administrator. The Administrator has sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Administrator decides in its sole discretion that the Claimant is entitled to them. In all cases, the determination of what constitutes a reasonable and customary amount for services has been delegated to the

Claims Administrator. The Administrator's decisions made pursuant to this Section are intended to be final and binding on Participants, beneficiaries and others.

Section 12.03 Exhaustion of Administrative Remedies. Claimants will not be entitled to challenge the Administrator's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable Program Document. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party. A Welfare Program may also permit an external review. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his or her right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within twelve (12) months following the date on which he or she submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures. If the Claimant does not bring such action within such twelve (12) month period, the Claimant will be barred from bringing an action under ERISA related to his or her claim.

Section 12.04 Limitations Period. If the Claimant has complied with and exhausted the appropriate claims procedures (including mandatory arbitration) and intends to exercise their right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within six (6) months following the date on which they submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures. If the Claimant does not bring such action within such six (6) month period, the Claimant will be barred from bringing an action under ERISA related to their claim. In addition, all claims for benefits must be submitted within twelve (12) months of the date of service or the date on which the claim was incurred.

Section 12.05 Incompetency. If any person entitled to payments under the Welfare Programs is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his or her financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision will apply. If the payment is to be made by an Insurance Company, such payment will be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Administrator, in its discretion, may direct that all or any portion of such payment be made:

(a) To such person;

(b) To such person's legal guardian or conservator; or

(c) To such person's Spouse or to any other person,

in any manner the Administrator considers advisable, to be expended for his or her benefit. The decision of the Administrator (or, where applicable, that of the Insurance Company) will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred will operate as a complete discharge of the obligations of the Welfare Programs, the Company, the Employers, the Administrator, and any Insurance Company, with respect to such payment.

See Appendices D and E attached hereto and incorporated by reference for Health Care and Disability Program claims procedures.

ARTICLE XIII
AMENDMENT AND TERMINATION

Section 13.01 Amendment. The Company reserves the discretionary right to modify or amend the Plan, including any Welfare Program listed on Appendix A hereto, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the managers of the Company, or its delegate. However, no Plan amendment will be valid which would cause the Plan to fail any applicable qualification requirements of Code Section 125 and any successors thereto, so long as such statute applies to this Plan. The Administrator will have the right to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Administrator that is inconsistent with any administrative, procedure or ministerial provision of the Plan will be deemed an amendment.

Section 13.02 Termination of the Plan. The Company reserves the right to terminate the Plan or any Welfare Program at any time. Such termination shall be implemented by a written instrument adopted by the managers of the Company and duly executed on behalf of the Company. Upon termination of the Plan, the Company will direct the Administrator to either restore any unused Account balances to the Compensation of each respective Participant or to continue to apply such balances towards Participants' benefits in accordance with Article VII for the remainder of the Plan Year, subject to forfeiture thereafter.

ARTICLE XIV
MISCELLANEOUS PROVISIONS

Section 14.01 Limitation of Rights. The establishment, maintenance and provisions of the Plan will not be considered or construed: (i) as giving to any Employee any right to continue in the employment of any Employer; (ii) as limiting the right of any Employer to discipline or discharge any of its Employees; (iii) as creating any contract of employment between any Employer and any Employee; or (iv) as conferring any legal or equitable right against the Administrator, the Company, or the Employers.

Section 14.02 Rights to Employers' Assets. No Participant will have any right to or interest in any assets of an Employer, except as specifically provided in this Plan. The Administrator will have no liability to any Participant, the Company or any Employer for making any payment or providing any benefit pursuant to this Plan, and will merely direct such payments to be made by the Company in accordance with the Plan.

Section 14.03 No Assignments. The right of a Participant (and/or the Participant's covered Dependents) to benefits under this Plan is personal to such individual and cannot be assigned in whole or in part to any person, hospital, provider, or other entity. For purposes of exercising the rights to benefits conferred under this Plan, an individual's "authorized representative" shall not include a provider, hospital, or any third-party organization acting on behalf of such entities. The right of any Participant to receive any benefits under the Plan will not be alienable by assignment,

either before or after benefits under this Plan are conferred. Further, the right of any Participant to receive any benefits under the Plan will not be subject to any claims by any creditor of or claimant against the Participant; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by the Participant to confer on any such creditor or claimant any right or interest with respect to such amounts, will be null and void, except as provided in Section 609 of ERISA with respect to QMCSOs. No Compensation reduction elections or other contributions under this Plan will cause any Company to be liable for, or subject to, any manner of debt or liability of any Participant.

Section 14.04 Severability. Any provision of the Plan will be severable, so that if any Plan provision is held invalid or unenforceable, such invalid or unenforceable provision will be severed from the Plan and the Plan will operate without regard to such severed provision. In such event, the Plan will be construed and enforced as if such severed provision had not been included herein, to the extent necessary to preserve the Section 125 Program's as a qualified "cafeteria plan" under Section 125 of the Code.

Section 14.05 No Guarantee of Tax Consequences. Neither the Company nor the Administrator makes any commitment or guarantee that amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes, or that any other federal, state, or local tax treatment will apply to or be available to any Participant. Each Participant is obligated to determine whether each payment under this Plan is excludible from the Participant's gross income for federal, state, and local income tax purposes.

Section 14.06 Venue. Any lawsuits brought pursuant to ERISA shall be filed and litigated in the U.S. District Court for the District of Nevada.

Section 14.07 Disputes. Any controversy or dispute arising out of or relating to this Plan that is not a claim for benefits under ERISA shall be subject to non-binding arbitration prior to the filing of a complaint in a court of law; provided, however, that such arbitration shall be final and binding and may be enforced in any court with the requisite jurisdiction if the parties agree in advance, in writing, that such arbitration shall have final, binding effect. All arbitration, whether binding or non-binding, shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place in the state of Nevada.

Section 14.08 Governing Law. The Plan will be construed in accordance with the laws of the state of Nevada (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law.

Section 14.09 Notifications to the Administrator. Unless otherwise stated herein, Participant notifications to the Administrator shall be made in writing or in any other such form approved by the Administrator (including electronic notification).

Section 14.10 Headings. All headings and captions used in this Plan are used as a matter of convenience and for reference only, and in no way will they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

ARTICLE XV
HIPAA PRIVACY & SECURITY

Section 15.01 Generally. The Company shall have access to PHI and Electronic PHI from the Plan only as permitted under the Plan and the HIPAA Privacy Policy. For purposes of this Article XVI, the "Company" shall mean the Company in its role as sponsor of the Plan. This Article XVI shall apply only to those Welfare Programs that are a "covered entity," as that term is defined under 45 C.F.R. Section 160.103; such Welfare Programs shall be referred to collectively as the "Plan" in this Article XVI.

Section 15.02 Provision of Protected Health Information to the Company.

(a) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Company information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Company, provided that the Company requests the Summary Health Information for the purpose of:

(i) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(ii) Modifying, amending, or terminating the Plan.

(c) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 15.02(d) and obtaining written certification pursuant to Section 15.04, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI and Electronic PHI to the Company, provided that the Company uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Company on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Company in connection with any other benefit or benefit plan of the Company or any employment-related actions or decisions. Further:

(i) Enrollment and disenrollment functions performed by the Company are performed on behalf of Plan Participants and beneficiaries and are not Plan administration functions. Enrollment and disenrollment information held by the Company is held in its capacity as an employer and is not PHI.

(ii) Notwithstanding any provisions of this Plan to the contrary, in no event shall the Company be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

(d) Conditions of Disclosure for Plan Administration Purposes. The Company agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. Section 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), the Company shall:

(i) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

(ii) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Company with respect to PHI;

(iii) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

(iv) Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

(v) Make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. Section 164.524;

(vi) Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 C.F.R. Section 164.526;

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(viii) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

(ix) If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) Ensure that the adequate separation between Plan and the Company (i.e., the firewall), required by 45 C.F.R. Section 504(f)(2)(iii), is established.

(e) Disclosure of Electronic PHI. The Company further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. Section 164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) Ensure that the adequate separation between the Plan and the Company (i.e., the firewall), required by 45 C.F.R. Section 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) Report to the Plan any security incident of which it becomes aware, as follows: the Company will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, the Company will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Section 15.03 Adequate Separation between Plan and the Company. The Company shall allow persons designated in the HIPAA Privacy Policy as "responsible employees" access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the administration functions that the Company performs for the Plan. In the event that a specified employee does not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Company for non-compliance pursuant to the Company's employee discipline and termination procedures. The Company shall ensure that the provisions of this Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

Section 15.04 Certification of the Company. The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Company only upon the receipt of a certification by the Company that the Plan has been amended to incorporate the provisions of 45 C.F.R. Section 164.504(f)(2)(ii), and that the Company agrees to the conditions of disclosure set forth in this Section of the Plan.

ARTICLE XVI
PARTICIPATING EMPLOYERS

Section 16.01 Adoption of Plan. Any entity that is an Affiliate of the Company may, with the Company's consent, adopt the Plan for the benefit of its eligible employees. The Affiliate must execute a Participation Agreement (or similar agreement approved by the Company) to adopt the Plan. The terms of such Participation Agreement are incorporated herein by reference.

Section 16.02 Revoking Adoption of a Plan. Any Affiliate that has elected to adopt the Plan in accordance with Section 16.01 may cease to participate in the Plan or in any Welfare Program with respect to its Participants by written notice to the Administrator. Upon revocation of participation in the Plan, the Affiliate may be required to make certain withdrawal payments to the Plan as described in the Participation Agreement referenced in Section 16.01 above.

Section 16.03 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Employer will be deemed to have authorized the Company and the Administrator of the Plan to act for it in all matters arising under or with respect to the Plan and will comply with such other terms and conditions as may be imposed by the Company and the Administrator.

Section 16.04 Company as Agent for Employers. The Company shall be the agent for each Employer with respect to the Plan. The Company shall exercise on an Employer's behalf all of the powers and authorities conferred upon the Company by the terms of the Plan, including, but not limited to, the power to amend and terminate the Plan. The authority of the Company to act as such agent will continue unless and until the Employer terminates participation in the Plan pursuant to Section 16.02.

IN WITNESS WHEREOF, the Company has caused this duly adopted Plan to be executed below by its duly authorized officer or representative on this 27 day of October, 2022 to be effective as of the Effective Date stated herein.

RENOWN HEALTH

By: Suzanne Oetjen

_____

Its: Interim Chief Human Resources Officer

COVID-19 ADDENDUM

Pursuant to EBSA Disaster Relief Notices 2020-01 and 2021-01, and the Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak, certain deadlines pertaining to the Plan are extended until the earlier of:

(a) one (1) year from the date (on or after March 1, 2020) that the Participant is first eligible for relief; or
(b) the end of the Outbreak Period (as defined below):

The thirty (30) day period (or sixty (60) day period, if applicable) to request a HIPAA special enrollment;

- The sixty (60 day election period for COBRA continuation coverage;
- The date/deadline for making COBRA premium payments;
- The deadline for individuals to notify the plan of a qualifying event or determination of disability;
- The deadline within which employees can file a benefit claim, or a claimant can appeal an adverse benefit determination, under the group health plan or disability plan claims procedures described in the Plan;
- The deadline for claimants to file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- The deadline for a claimant to file information to perfect a request for external review upon finding that the request was not complete.

"Outbreak Period." The "outbreak period" began March 1, 2020, and extends until sixty (60) days after the end of the National Emergency or such other date as announced by the IRS and DOL, or otherwise declared by the Federal government as a result of the national emergency due to the COVID-19 pandemic.

"National Emergency." The National Emergency means the March 13, 2020, Proclamation on Declaring a National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Outbreak" issued by President Trump and President Trump's determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121, et seq., that a national emergency exists as a result of the COVID-19 pandemic.

ATTACHMENTS

(Policies, Plans, Programs and Booklets of Offered Benefits)

APPENDIX A
COMPONENT WELFARE PROGRAMS AND ADMINISTRATORS

Effective as of January 1, 2022

The following Welfare Programs are included in the Plan.

Medical Program (including prescription benefits and vision benefits

Dental Program

Accidental Death & Dismemberment Insurance

Group Life Insurance

Employee Assistance Program (EAP)

Long Term Disability Plan

Provider Short-Term Disability

Short-Term Disability

Universal Life Insurance with Living Benefit

Accident Insurance

Critical Illness

Hospital Indemnity

Identity Theft Protection

Legal Services Plan

Commuter Benefits

APPENDIX B
PARTICIPATING EMPLOYERS

As of January 1, 2022, unless otherwise noted below the Affiliates that are Participating Employers in the Plan are as follows**:**

__94-2972845___ FEIN

This Appendix B shall be deemed amended at such time as a Participating Employer adopts this Plan or revokes participation in the Plan in accordance with the procedures set forth in Article XVI.

Each entity listed above has sufficient common ownership with the Employer so as to constitute a member of a commonly controlled group as described in Code §§414(b), (c), and (m) and has adopted the Plan with the consent of the Plan Sponsor.

APPENDIX C

OFFER OF MINIMUM ESSENTIAL COVERAGE

Section C1 Generally. The Company intends for the Plan to be administered in such a way to avoid the imposition of penalties under Code Section 4980H with respect to Employers who participate in this Plan. In the event of any ambiguity in this Plan document, the Plan shall be interpreted to avoid penalties under Code Section 4980H. The Company provides coverage for Full-Time and Part-Time Employees scheduled to work twenty (20) Hours of Service per week at the time of hire. Variable Hour Employees who work per diem shifts and not expected to work twenty (20) or more hours per week are offered coverage following a twelve (12) month Measurement Period and will be eligible for coverage during the following twelve (12) month Stability Period. Any penalties or liability under Code Section 4980H shall only attach as applicable with respect to Full-Time Employees.

Section C2 Definitions. For purposes of this Appendix B, the terms below are defined as follows:

(a) "Administrative Period" means the period beginning immediately following the end of a Measurement Period and ending immediately before the start of the associated Stability Period. The Administrative Period also includes the period between a new employee's start date and the beginning of the Initial Measurement Period if the Initial Measurement Period does not begin on the Employee's start date.

(b) "Affordable Coverage" shall have the meaning set forth in Treas. Reg. § 54.4980H-5(e).

(c) "Full-Time Employee" means a common law Employee of the Employer who performs an average of at least thirty (30) Hours of Service per week, determined under Section C3 below, in a manner consistent with Treas. Reg. § 54.4980H-3.

(d) "Hour of Service" means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. The term Hour of Service does not include: (i) any hour for services performed as a bona fide volunteer, (ii) any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 C.F.R. Section 675 or a substantially similar program of a State or political subdivision thereof, or (iii) any hour for services to the extent the compensation for those services constitutes income from sources outside of the United States.

(e) "Initial Measurement Period" means the period of twelve (12) consecutive months beginning on a newly-hired Variable Hour Employee's start date or the first day of the first calendar month beginning after such Variable Hour Employee's start date, for purposes of determining

whether a Variable Hour Employee has provided an average of thirty (30) or more Hours of Service per week.

(f) "Measurement Period" means either the Initial Measurement Period or a Standard Measurement Period.

(g) "Minimum Essential Coverage" means the coverage options offered through the medical Welfare Program component of the Plan that meets the requirements of "minimum essential coverage" under the Affordable Care Act.

(h) "Part-Time Employee" means a common law Employee of Employer who performs an average of more than twenty (20) Hours of Service per week, but less than thirty five (35) Hours of Service per week.

(i) "Stability Period" means the period that immediately follows, and is associated with, a Measurement Period and the Administrative Period associated with that Measurement Period.

(j) "Standard Administrative Period" means the Administrative Period following the end of the Standard Measurement Period, as described in Treas. Reg. § 54.4980H 1(a)(1).

(k) "Standard Measurement Period" means each twelve (12) month period as determined by the Plan Administrator in its sole and absolute discretion. The dates for the Standard Measurement Period are determined by the Plan Administrator each year.

(l) "Standard Stability Period" means the twelve (12) month Stability Period that is associated with the Standard Measurement Period. The Standard Stability Period begins on January 1 of each Plan Year and ends on December 31 of the same Plan Year.

(m) "Variable Hour Employee" means a common law Employee of Employer who is not classified as a Full-Time Employee or a Part-time Employee and for whom, based on the facts and circumstances at the Employee's start date, the Company cannot determine whether the Employee is reasonably expected to provide on average at least thirty (30) Hours of Service per week during the Initial Measurement Period because the Employee's hours are variable or otherwise uncertain. Per Diem Employees are considered Variable Hour Employees.

Section C3 Eligibility and Waiting Periods.

(a) Full-Time Employees and Part-Time Employees shall be eligible for coverage under the Medical Program in accordance with the Medical Program no later than thirty (30) days following their date of hire (subject to timely enrollment in the Plan).

(b) Following the Initial Measurement Period, Variable Hour Employees who average thirty (30) or more Hours of Service per week shall be eligible for coverage under the Medical Program beginning as of the first day of their Initial Stability through at least the last day the Variable Hour Employee's Initial Stability Period, provided the Employee remains employed during the Initial Stability Period.

(c) Ongoing Employees. This subsection (c) applies to Employees on the day preceding the first day of the Plan Year. The Employer shall determine whether such Employees are Full-Time, Part-Time or Variable Hour Employees working less than thirty (30) Hours of Service per week by calculating the average hours worked during the applicable Standard Measurement Period, as described in Treas. Reg. § 54.4980H-3(d). Such determination shall be effective for the Standard Stability Period immediately following the Standard Administrative Period that relates to such Standard Measurement Period.

(c) Determination by IRS. This subsection (c) applies to Employees who are not offered Minimum Essential Coverage within the time prescribed in Section C4 below. If, after the beginning of a Plan Year, an Employee is subsequently classified as a Full-Time Employee by the Internal Revenue Service for purposes of assessing the Code Section 4980H penalty against an Employer, the Employee shall be considered a Full-Time Employee prospectively as of the date of the IRS' determination and offered Minimum Essential Coverage as described in Section C4. Additionally, the Plan shall have discretion to retroactively enroll the Employee for coverage as a Full-Time Employee, consistent with any applicable federal laws.

Section C4 Offer of Coverage. The Employer shall offer Minimum Essential Coverage to Full-Time Employees and Part-Time Employees. Such offer of coverage shall be made upon the date of hire or, if applicable, within the "limited non-assessment period" prescribed in Treas. Reg. § 54.4980H-1(a)(26). Notwithstanding the foregoing, the Employer shall have the discretion to exclude certain Full-Time Employees from coverage under the Plan, but only if such exclusion does not cause any Employer to be subject to a tax penalty under Code Section 4980H(a).

Section C5 Change in Employment Status. This Section C5 applies to Employees if their employment status changes during a Stability Period or the Initial Measurement Period.

(a) If an ongoing Full-Time or Part-Time Employee experiences a change in employment status before the end of a Stability Period, the change will not affect the application of the Employee's classification as a Full-Time or Part-Time Employee, for the remaining portion of the Stability Period.

(b) If a new Variable Hour Employee experiences a change in employment status before the end of the Initial Measurement Period such that, if the Employee had begun employment in the new position or status and would have been classified as a Full-Time Employee, the Employer will not be subject to an assessable payment under Code Section 4980H for the period before the first day of the fourth (4th) full calendar month following the change in employment status (or, if earlier and the Employee averages thirty (30) or more hours of service per week during the Initial Measurement Period, the first day of the first month following the end of the Initial Measurement Period (including any Administrative Period associated with the Initial Measurement Period)), provided that the Employer offers the employee Minimum Essential Coverage no later than the end of such period.

(c) An Employee may revoke an election of Minimum Essential Coverage during a period of coverage provided the following conditions are met:

(1) The Employee has been in an employment status under which the Employee was reasonably expected to average at least thirty (30) Hours of Service per week and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than thirty (30) Hours of Service per week after the change, even if that reduction does not result in the Employee ceasing to be eligible under the Medical Program; and

(2) The revocation of the election of coverage under the Medical Program corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another medical plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Section C6 Breaks in Service. An Employee who resumes providing services to the Employer after a period during which the Eligible Employee was not credited with any Hours of Service may be treated as a new Eligible Employee, only if such Employee's break in service was at least thirteen (13) consecutive weeks long. Otherwise, the Employee shall be treated as a continuing Eligible Employee, with the same status such Eligible Employee would have had during the Stability Period during which such Eligible Employee resumed services. The Employer must offer Minimum Essential Coverage to a continuing Eligible Employee treated as a Full-Time Employee by no later than the first day of the calendar month following resumption of services.

Section C7 Affordability. If the Employer is charged with a penalty under Code Section 4980H(b) because the Minimum Essential Coverage offered to a Full-Time Employee is not Affordable Coverage, the Plan shall have the discretion to reduce the cost of coverage for such Employee.

APPENDIX D

HEALTH CARE CLAIMS PROCEDURES

1. Application of Benefits

A Covered Person shall comply with such rules and procedures as the Claims Administrator may prescribe with respect to the completion and filing of a written claim application form or forms and shall furnish such other pertinent information as the Claims Administrator may require, together with documentary evidence in support of the claim. A Covered Person must also provide the Claims Administrator with written authorization to obtain information from their Physician pertaining to the diagnosis and related matters. The Plan Administrator, at its own expense, shall have the right and opportunity to require the examination of the person whose Illness or Injury is the basis of a claim hereunder, when and so often as may reasonably be required during the pendency of such claim. Claims for benefits provided through insurance contracts will be determined by the insurance carrier providing such benefits. Claims for benefits that are funded by the Employer shall be determined by the appropriate Claims Administrator as delegated by the Plan Administrator.

2. Definitions. The following terms shall have the meaning described below for purposes of this Exhibit:

2.1 "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not medically necessary or appropriate. An "Adverse Benefit Determination" also includes any "Rescission of Coverage," as defined in this Section 2.1 (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

2.2 "Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(b) 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.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

2.3 "External Review" means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to an applicable external review process described in this Exhibit.

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

2.5 "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process described in this Article (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules set forth in this Exhibit).

2.6 "Health Care Professional" means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

2.7 "Independent Review Organization" (or "IRO") means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to the terms of this Exhibit.

2.8 "Notice" or "Notification" means the delivery or furnishing of information to an individual in a manner that is reasonably calculated to ensure actual receipt by the individual.

2.9 "Pre-service Claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

2.10 "Post-service Claim" means any claim for a benefit under the Plan that is not a Pre-service Claim.

2.11 "Relevant" means that a document, record, or other information regarding a claim either:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(c) Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or

(d) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

2.12 "Rescission of Coverage" means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a Rescission of Coverage if (i) the cancellation or discontinuance of coverage has only a prospective effect; (ii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (iii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to fraud or intentional misrepresentation of material fact, provided that this clause (iii) shall apply only if at least thirty (30) days advance written notice of the right to rescind for fraud or misrepresentation is furnished to each participant.

For example, if an Employee is reassigned to a position where they are no longer eligible for Plan coverage, but the Plan mistakenly continues to provide coverage, collect premiums from the employee and pay claims submitted by the employee, the Plan cannot rescind the employee's coverage retroactive to the date the employee ceased to be eligible for the Plan. In this example, the Plan may cancel coverage for the employee prospectively, subject to other applicable laws.

3. Time for Notification of Decision. The Claims Administrator shall notify a claimant of the Plan's benefit determination in accordance with the following:

3.1 Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical circumstances, but not later than seventy two (72) hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the claimant as soon as possible, but not later than twenty four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty eight (48) hours, to provide the specified information. Notification of any Adverse Benefit Determination shall be made in accordance with Section 4. The Claims Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty eight (48) hours after the earlier of:

(a) The Plan's receipt of the specified information, or

(b) The end of the period afforded the claimant to provide the specified information.

3.2 Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(a) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claims Administrator shall

notify the claimant, in accordance with Section 4, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(b) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical circumstances, and the Claims Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Section 4.

3.3 Other Claims. In the case of a claim not described in Section 3.1 or 3.2, the Claims Administrator shall notify the claimant of the Plan's benefit determination in accordance with the following:

3.4 Pre-Service Claims.

(a) In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the Notice of Extension shall specifically describe the required information, and the claimant shall be afforded at least forty five (45) days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination shall be made in accordance with Section 4.

(b) Subject to paragraph (c) below, in the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days twenty four (24) hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral unless written notification is requested by the claimant or authorized representative.

(c) Paragraph (b) of this Section shall apply only in the case of a failure that:

(i) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(ii) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

3.5 Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall notify the claimant, in accordance with Section 4, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30)-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the Notice of Extension shall specifically describe the required information, and the claimant shall be afforded at least forty five (45) days from receipt of the notice within which to provide the specified information.

4. Content of Notification.

4.1 Except as provided below, the Claims Administrator shall provide a claimant with written or electronic Notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b 1(c) (l) (i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

(e) Whichever of the following applies:

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(ii) If the Adverse Benefit Determination 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, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(f) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim a description of the expedited review process applicable to such claims.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Claim, the information described in 4.1may be provided to the claimant orally within the time frame prescribed in Section 3.1(a), provided that a written or electronic Notification in accordance with this Section 4 is furnished to the claimant not later than three (3) days after the oral Notification.

5. Appeal of Adverse Benefit Determination. A claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Plan Administrator, and under which there will be a full and fair review of the claim and the Adverse Benefit Determination. In conducting such review, the Plan Administrator may, in its sole and absolute discretion, consult with such advisors as it deems appropriate. Such full and fair review shall:

5.1 Provide claimants at least one hundred and eighty (180) days following receipt of a Notification of an Adverse Benefit Determination within which to appeal the determination;

5.2 Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

5.3 Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits;

5.4 Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

5.5 Provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

5.6 Provide that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

5.7 Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

5.8 Provide that the Health Care Professional engaged for purposes of a consultation under Section 5.6 shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

5.9 Provide, in the case of a Claim Involving Urgent Care, for an expedited review process pursuant to which:

5.10 A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant; and

5.11 All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

6. Timing of Benefit Determination on Review. The Plan Administrator shall notify the claimant of the Plan's benefit determination following each appeal described in Section 5 in accordance with the following:

6.1 Urgent Care Claim. In the case of a Claim Involving Urgent Care, the Plan Administrator shall notify the claimant, in accordance with Section 7, of the Plan's benefit determination on review as soon as possible, taking into account the medical circumstances, but not later than seventy two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan.

6.2 Pre-Service Claims. In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant, in accordance with Section 7 of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt by the Plan of the claimant's request for review of the Adverse Benefit Determination.

6.3 Post-Service Claims. In the case of a Post-Service Claim, the Plan Administrator shall notify the claimant, in accordance with Section 7, of the Plan's benefit determination on review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the claimant's request for review of the Adverse Benefit Determination.

6.4 Furnishing Documents. In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in Section 7 as is appropriate.

7. Content of Notification on Review. The Plan Administrator shall provide a claimant with written or electronic Notification of a Plan's benefit determination following an appeal described in Section 5. Any electronic notification shall comply with the standards imposed by 29 CFR

2520.104b 1(c)(l)(i), (iii), and (iv). In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the claimant:

7.1 The specific reason or reasons for the adverse determination;

7.2 Reference to the specific Plan provisions on which the benefit determination is based;

7.3 A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits;

7.4 A statement of the claimant's right to bring an action under section 502(a) of ERISA;

7.5 If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

7.6 If the Adverse Benefit Determination 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, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7.7 The following statement: "The Covered Person and the Covered Person's Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the Covered Person's local U.S. Department of Labor office and the Covered Person's State insurance regulatory agency."

8. Avoiding Conflicts of Interest.

The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

9. Additional Notice Requirements.

The notices described in the foregoing provisions of this Article shall be provided in a culturally and linguistically appropriate manner, as follows:

9.1 The Plan shall ensure that any Notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its

corresponding meaning, and the treatment code and its corresponding meaning). The Plan must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

9.2 The Plan shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

9.3 The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

9.4 The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

9.5 The Plan shall provide notices upon request in a non-English language in which ten percent or more of the population residing in the United States county to which the notice is sent is literate only in the same non-English language, as determined in guidance published by the Secretary of the Treasury or Secretary of Labor. In such a case, the Plan shall also: (i) include in the English versions of all notices, a statement, prominently displayed in any applicable non-English language, offering the provision of such Notices in the non-English language and clearly indicating how to access the language services provided by the Plan; (ii) once a request has been made by a claimant, provide all subsequent Notices to the claimant in the non-English language; and (iii) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including External Review) in any applicable non-English language.

10. Deemed Exhaustion of Internal Claims Processes.

If the Plan fails to strictly adhere to all the internal claim and appeal requirements of this Article with respect to a claim, the claimant is deemed to have exhausted such internal claims and appeals process, regardless of whether the Plan asserts that it substantially complied with such requirements or that any error it committed was de minimis. In such a case, the claimant may initiate an External Review under Sections 13 and 14 and is entitled to pursue any available remedies under Section 502(a) of ERISA.

Notwithstanding the preceding paragraph, the internal claims and appeals requirements of this Article will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific

description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals requirements of this Article to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the Plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

11. Continued Coverage Pending Outcome of Appeal.

The Plan shall provide continued coverage pending the outcome of an appeal. For this purpose, the Plan shall comply with the requirements of 29 C.F.R. § 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

12. External Review Process.

The External Review process described in Section 13 (Standard External Review) and Section 14 (Expedited External Review) applies only to (i) an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and (ii) a Rescission of Coverage (whether or not the rescission has any effect on any particular benefit at that time). The limitation on the scope of External Review set forth in this paragraph shall remain in effect until it is revoked in guidance published by the Secretary of the Treasury or the Secretary of Labor.

13. Standard External Review.

This Section 13 sets forth procedures for standard External Review, which is External l Review that is not considered expedited. The expedited External Review process is described in Section 14.

13.1 Request for External Review. The Plan shall allow a claimant to file a request for an External Review with the Plan if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5^{th}) month following the receipt of the notice. For example, if the date of receipt of the notice is February 30th, because there is no February 30th, the request must be filed by March 1st. 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.

13.2 Preliminary Review. Within five (5) business days following the date of receipt of the External Review request, the Plan shall complete a preliminary review of the request to determine whether:

The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(a) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination is eligible for External Review pursuant to Section 12;

(b) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the Plan's internal appeal process under Section 10; and

(c) The claimant has provided all the information and forms required to process an External Review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a notification in writing to the claimant. If the request is complete but not eligible for External Review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-3272). If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Plan shall allow the claimant to perfect the request for External Review within the four (4) month filing period or within the forty eight (48) hour period following the receipt of the notification, whichever is later.

13.3 Referral to Independent Review Organization. The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. A contract between the Plan and an IRO must provide the following:

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(a) The assigned IRO will 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 assigned 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 business days.

(b) Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the External Review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit

Determination or Final Internal Adverse Benefit Determination. Within one (1) business day after making the decision, the IRO must notify the claimant and the Plan.

(c) Upon receipt of any information submitted by the claimant, the assigned IRO must within one (1) business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan must not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;

(iv) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(v) 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;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(e) The assigned IRO must provide written notice of the final External Review decision within forty five (45) days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to the claimant and the Plan.

(f) The assigned IRO's decision notice will contain:

(i) A general description of the reasons 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);

(ii) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) 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 on in making its decision;

(v) 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 Plan or to the claimant;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

13.4 After a final External Review decision, the IRO must maintain records of the claims and notices associated with the External Review process for six (6) years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

13.5 Reversal of Plan's Decision. Upon receipt of a notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

14. Expedited External Review.

14.1 Request for Expedited External Review. The Plan shall allow a claimant to make a request for an expedited External Review with the Plan at the time the claimant receives:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a Facility.

14.2 Preliminary Review. Immediately upon receipt of the request for expedited External Review, the Plan must determine whether the request meets the reviewability requirements set forth in Section 13.2 for standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section 13.2 for standard External Review to the claimant of its eligibility determination.

14.3 Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in Section 13.3 for standard review. The Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit 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, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

14.4 Notice of Final External Review Decision. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth in Section 13.3 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 that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

15. Calculating Time Periods. The period of time within which a benefit determination (including a benefit determination on review) is required to be made shall begin at the time a claim (or appeal) is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted in this Article due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

16. Payment of Benefits. Benefits are payable to the Covered Person whose Illness or Injury is the basis of their claim under this Plan, except when an application for benefits does not include satisfactory proof that charges made by providers of health care services for which this Plan's benefits are payable have been paid by or on behalf of the Covered Person, all or a portion of any

benefits provided by the Plan may, at the Plan Administrator's option, be paid directly to the provider of health services.

Notwithstanding any provision of this Exhibit, this Plan shall recognize the terms of a Qualified Medical Child Support Order. Payment for Plan benefits with respect to a Covered Employee will be made in accordance with any assignment of rights made by or on behalf of such Covered Member or a covered Dependent of the Covered Employee as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on August 10, 1993).

To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which this Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Member to such payment for such items or services.

17. Assignment. No benefit payable under the Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same shall be void.

17.1 No Covered Person entitled to benefits under the Plan shall have power to transfer, assign, mortgage or otherwise encumber any interest they may have herein, or to anticipate in any manner by assignment, agreement (including, but not limited to, any agreement to pay alimony, separate maintenance or child support, whether or not said agreement is pursuant to, or embodied in, a court order), or otherwise, the payment of any benefit or any other sum herein provided for him to be made; nor shall the interest of any Covered Person under this Plan or in any benefit provided hereunder be subject to attachment, garnishment, seizure or sequestration for the payment of any debts, judgments, decrees or obligations of any kind owed by such person (including, but not limited to, any obligation to pay alimony, separate maintenance or child support for which said person shall be obligated by virtue of a court order or decree of any court of any jurisdiction or by virtue of any agreement whether or not embodied in such a court order or decree), or be transferable by operation of law in event of bankruptcy, insolvency or otherwise.

17.2 Notwithstanding any provision of this Section 17, and subject to any written direction of the Covered Person, all or a portion of any benefits provided by the Plan on account of any medical services may, at the Plan's option, be paid directly to the provider of such services.

18. Facility of Payment. Whenever and as often as any person entitled to payments hereunder shall be determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage their financial affairs, the Employer, in its discretion, may direct that all or any portion of the benefit payments be made: (a) to such person; (b) to such person's legal guardian or conservator; or (c) to such person's Spouse or to any other person. The decision of the Employer shall, in each case, be final and binding upon all persons. Any payment made pursuant to the authority herein conferred shall operate as a complete discharge of the obligations of the Employer under the Plan in respect hereof.

19. Responsibility for Payment. The Employer shall be liable for the payment of benefits in accordance with the terms of the Plan. The benefits under the Plan shall be payable solely by the

Employer and each Covered Person who shall claim the right to any payment under the Plan shall be entitled to look only to Plan for such payment.

APPENDIX E

DISABILITY CLAIMS PROCEDURES

In the event a Welfare Program that provides disability benefits does not include claims procedures within the policy documents, the benefits will be determined according to the following procedures:

(1) Time Limits for Initial Claims. If a Participant believes they are entitled to receive a Disability benefit under the Plan, including one greater than that initially determined by the Administrator, the Participant may file a claim in writing with the Administrator. The Administrator (or their designee) will, within forty five (45) days of the receipt of a claim, either grant or deny the claim in writing. An extension of thirty (30) days will be allowed for processing the claim if necessary due to matters beyond the Disability Program's control. In such case the Participant will receive notice of such extension before the expiration of the initial forty five (45) day period. The notice will state the special circumstances involved and the date a decision is expected. If, before the end of the first thirty (30) day extension period, the Administrator determines that, due to matters beyond the control of the Disability Program, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, and the Participant will receive an additional notice before the expiration of the first thirty (30) day extension period of the circumstances requiring the additional extension and the date as of which the Disability Program expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Participant will then be afforded at least forty five (45) days within which to provide the additional information. If additional information is requested to resolve the issues, the time period allowed for making the benefits determination is tolled from the date the notice is sent to the Participant until the date the Participant responds to the notice.

(2) Notice of Initial Denial. The Administrator's denial of a claim will be written in a manner calculated to be understood by the average Participant and will include:

(a) the specific reason or reasons for the benefit determination;

(b) references to specific Disability Program provisions on which the benefit determination is based;

(c) a description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;

(d) a statement that the Participant 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;

(e) an explanation of the appeal procedure;

(f) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(g) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Disability Program's terms to the Participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(h) a statement that the Participant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(3) Right to Appeal. If the claim is denied in whole or in part by the Administrator, the Participant or their authorized representative may, within one hundred and eighty (180) days after receipt of denial of the claim or, if no notice of denial was received, within one hundred and eighty (180) days of the date the notice should have been provided:

(a) submit a written request for review by the Administrator;

(b) receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Participant's claim; and

(c) submit written comments, documents, records and other information relating to the claim for benefits.

(4) Independent Review. The review of the initial decision concerning the Participant's disability claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and will consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made. The decision maker will also consider any information submitted by the Participant.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Disability Program will disclose to the Participant the identity of medical or vocational experts whose advice was obtained by the Disability Program in connection with the review, even if the advice was not relied upon in making the final decision.

(5) Time Limits for Decision on Appeal. The Administrator will furnish the Participant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within forty five (45) days of the date in which the written appeal was submitted. The Administrator may take an additional forty five (45) days to make this decision if special circumstances are present. The Administrator will give the Participant notice if this extension is necessary before expiration of the

initial forty five (45) day period. In no event will such extension exceed a period of forty five (45) days from the end of the initial forty five (45) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Disability Program expects to render the determination on review.

(6) Notice of Decision on Appeal. The decision concerning an appeal of a claim will be written in a manner calculated to be understood by the average Participant and will include:

(a) the specific reason or reasons for the benefit determination;

(b) references to specific Disability Program provisions on which the benefit determination is based;

(c) a statement that the Participant 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 Participant's claim;

(d) an explanation of any voluntary appeal procedures offered by the Disability Program, if any;

(e) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(f) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Disability Program's terms to the Participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(g) a statement that the Participant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(7) Notwithstanding the foregoing, a Participant may not seek benefits under the Disability Program in judicial or administrative proceedings without first complying with and fully exhausting these procedures. In addition, the Participant must bring civil action under ERISA Section 502(a) within two (2) years after the Participant's initial claim or within six (6) months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Disability Benefit Program. The decisions made pursuant to these procedures are final and binding on the Participant and any other party.

SPECIAL ADDENDUM

RETIREE COVERAGE

1. In General. In addition to eligibility and benefits provisions stated in the Plan document, the Plan provides benefits to eligible retired Employees in accordance with the terms of this Special Addendum.

2. Coverage. Retiree health coverage under this Plan includes the Medical (including pharmacy and vision) and Dental programs only.

3. Procedure for "Category I" retirees. "Category I" retiree means any former employee of Renown Health System who retired from Renown Health System and is eligible to receive retiree medical benefits after meeting the following eligibility requirements:

3.1 *Eligibility*.

(a) A retiree must have been an active full or regular part-time employee who retired from Renown Health service on or before December 31, 1993; and

(b) The retiree may continue medical benefits for themselves, spouse and/or dependent(s) if the retiree, spouse and/or dependent(s) were covered under Renown's Medical or Dental Plan on the retiree's date of retirement. Retirement must be immediately subsequent to employment with Renown Health.

3.2 *Rates*. Renown Health will continue to subsidize a "Category I" Retiree's health insurance rate equal to that amount paid by Renown Health on January 1, 1994, for similar coverage as for active employees. This subsidy is for that coverage the retiree has in effect upon their retirement. Should an insurance rate change from the January 1, 1994 rate, Renown Health will subsidize a retiree at the January 1, 1994 rate or the new insurance rate whichever is less. The retiree will be responsible for any difference in rate between Renown Health subsidy and the prevailing rate.

3.3 *Open Enrollment*. Retirees may change enrollment options during an open enrollment period (lasting thirty (30) days) once each year. Dependents may not be added to coverage after the "Category I" retiree's date of retirement. However, changing from the Self-insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-insured Health Plan is not allowed.

3.4 *Duration of Benefits*. "Category I" retirees covered by Renown Health's medical plan on the day of retirement will be eligible for retiree medical benefits. When the "Category I" retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

4. Procedure for "Category II" retirees. "Category II" retiree means any Renown Health employee on active full-time or regular part-time status who retires from Renown Health after meeting the following eligibility requirements:

4.1 *Eligibility*.

(a) The employee must have been hired before January 1, 1990, and be a participant in Renown Health's Retirement Income Plan (RIP), and

(b) The employee must be enrolled in the Renown Health Medical plan. A spouse and/or eligible dependent(s) must be enrolled in one of the Renown Health's medical benefits plans at least two (2) years prior to the employee's date of retirement to be eligible for continuing benefits. Retirement must be immediately subsequent to employment with Renown Health.

4.2 *Rate*. Renown Health will subsidize a "Category II" Retiree's health insurance rate equal to that amount paid by Renown Health on January 1, 1994, for similar coverage as for active employees as outlined below. This subsidy is for that coverage the retiree has in effect upon retirement.

(a) A "Category II" retiree will receive one hundred percent (100%) of Renown Health subsidy for retiree health benefits. This subsidy is equal to the January 1, 1994 rate, which is equivalent to that amount paid by Renown Health on January 1, 1994 for similar coverage as for an active employee. To receive this subsidy, the employee must retire on or before December 31, 1995, in accordance with the rules governing retirement eligibility under Renown Health's Retirement Income Plan or has attained a minimum age of fifty five (55) but no more than fifty nine (59) years of age with at least a minimum of thirty (30) years of service on or after January 1, 1996.

(b) If a "Category II" employee retires on or after January 1, 1996 and does not meet the eligibility requirements as set forth in the paragraph immediately above, the Renown Health subsidy will be fifty percent (50%) of the January 1, 1994 rate which is equivalent to that amount paid by the Renown Health on January 1, 1994, for similar coverage as for an active employee.

(c) Should an insurance rate change from a January 1, 1994 rate, Renown Health will subsidize retirees at the January 1, 1994 rate or the new insurance rate whichever is less. The retiree will be responsible for any difference in amount between the Renown Health subsidy and the prevailing rate.

4.3 *Open Enrollment*. Retirees may change enrollment options during an open enrollment period (lasting thirty (30) days) once each year. Dependents may not be added to coverage after the "Category II" retiree's date of retirement. Changing from the Self-insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-insured Health Plan is not allowed.

4.4 *Duration of Benefits*. Eligible "Category II" retirees will be covered by medical insurance offered by Renown Health on the day of retirement. When the "Category II" Retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

5. Procedure for Category III retirees. "Category III: retiree means any Renown Health employee on active full-time or regular part-time status who retires from Renown Health and is eligible for retiree medical benefits after meeting the following requirements:

5.1 *Eligibility*.

(a) The employee must have been hired before January 1, 1990 and;

(b) Have a minimum of ten (10) years of continuous service immediately prior to attaining age 60, or,

(c) Qualifies for early retirement under rules governing the Custom Save plan; and

(d) Be enrolled in a Renown Health medical benefits plan on the date of retirement. A spouse and/or eligible dependent(s) must be enrolled in one of Renown Health's medical benefits plans at least two (2) years prior to the employee's date of retirement to be eligible for continuing benefits. Retirement must be immediately subsequent to employment with Renown Health.

5.2 *Rate*. Renown Health will subsidize a "Category III" retiree's health insurance rate as follows. This subsidy is for that coverage the retiree has in effect upon their retirement.

(a) If an employee retires on or before December 31, 1995, under eligibility requirements specified in Paragraphs (1) and (2) above, Renown Health subsidy for retiree health benefits will be equal to the January 1, 1994 rate which is equivalent to that rate paid by Renown Health on January 1, 1994, for similar coverage as for an active employee.

(b) If the employee retires on or after January 1, 1996, under eligibility requirements specified in Paragraph (1) above, (employees who take early retirement after January 1, 1996, under Custom Save rules are not eligible for retiree medical benefits), Renown Health subsidy will be fifty percent (50%) of the January 1, 1994 rate which is equivalent to that rate paid by Renown Health on January 1, 1994, for similar coverage as for an active employee.

(c) Should insurance rates change from the January 1, 1994 rate, Renown Health will subsidize retirees at the January 1, 1994 rate or the new insurance rate whichever is less. The retirees will be responsible for any difference in amount between Renown Health subsidy and the prevailing rate.

5.3 *Open Enrollment*. Retirees may change enrollment options during an open enrollment period (lasting thirty (30) days) once each year. Dependents may not be added to coverage after the "Category III" Retiree's date of retirement. Changing from the Self-Insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-Insured Health Plan is not allowed.

5.4 *Duration of Benefits*.

(a) "Category III" retirees covered by medical insurance offered by Renown Health on the day of retirement who retire on or before December 31, 1995, will be eligible for retiree medical benefits. When the Category III Retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

(b) "Category III" retirees covered by medical insurance offered by Renown Health on the day of retirement which is on or after January I, 1996, will be eligible for retiree medical benefits. When the retiree is eligible for Medicare or other government sponsored or legislated medical coverage, Renown Health benefits will be discontinued.

6. Procedure for "Category IV" retirees. "Category IV" Retirees are those full-time and regular part-time employees hired after January I, 1990. These employees are eligible for COBRA benefits as provided under the Renown Health medical insurance plan. They are not eligible for any other Renown Health provided retiree medical benefits.

7. Reservation of Rights. Renown Health reserves the right to amend, modify or terminate benefits for retirees under this Special Addendum at any time without notice.

CERITFIED COPY OF RESOLUTIONS
OF THE
RENOWN HEALTH EMPLOYEE BENEFITS REVIEW COMMITTEE

[Adoption of Amended and Restated Welfare Plan Document]

The undersigned Chair of the Employee Benefits Review Committee of Renown Health (the "Committee") hereby certifies that the following resolutions were adopted at a meeting of the Committee duly convened and properly conducted on November 11, 2022.

WHEREAS, the Committee wishes to amend and restate the Renown Health Welfare Benefits Plan to incorporate recent amendments and legal updates.

NOW, THEREFORE, BE IT RESOLVED, that the Committee hereby approves and adopts the amended and restated Renown Health Welfare Benefits Plan in the form attached hereto.

FURTHER RESOLVED, that the proper officers of Renown Health be, and each of then hereby is, authorized and directed in the name and on behalf of the Committee to take any and all such actions as they in their discretion deem appropriate or as any such officers may, with the advice of counsel, deem necessary or desirable to comply with applicable law and regulations and otherwise carry out the intent of the resolutions.

RENOWN HEALTH

By: DocuSigned by: EAB90A93A462438...

Title: Director of HR Business Partners

Date: 11/11/2022 | 09:49 PST