

**FLUOR FEDERAL SERVICES, INC.  
PADUCAH DEACTIVATION PROJECT  
HEALTH & WELFARE PLAN**

**Effective as of October 1, 2015**

Fluor Federal Services, Inc.  
Paducah, Kentucky

**FLUOR FEDERAL SERVICES, INC. PADUCAH DEACTIVATION PROJECT  
HEALTH & WELFARE PLAN**

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**FLUOR FEDERAL SERVICES, INC. PADUCAH DEACTIVATION PROJECT GROUP  
HEALTH & WELFARE PLAN**

**ARTICLE I  
PREAMBLE**

**Section 1.1 The Plan.**

The Fluor Federal Services, Inc. Paducah Deactivation Project (FPDP) Health & Welfare Plan (“Plan”), Plan 501, is amended and restated effective as of October 1, 2015.

**Section 1.2 Purpose and Intent.**

The purpose of the Plan is to provide to Participants, their Dependents and Beneficiaries certain welfare benefits described herein and to supplement the Summary Plan Descriptions and insurance contracts for the Welfare Programs identified in Appendix A. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA.

The Plan is intended to meet all applicable requirements of the Internal Revenue Code (“Code”) and the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended, as well as rulings and regulations issued or promulgated thereunder. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply.

**Section 1.3 Definitions.**

The following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein:

- (a) **“Beneficiary”** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.
- (b) **“Board of Directors”** means the Board of Directors of the Company.
- (c) **“Child” or “Children”** means a covered Child under the Plan as defined under the terms of the respective Welfare Program.
- (d) **“Child/Children of a Domestic Partner”** means a covered Child of a Domestic Partner under the Plan as defined under the terms of the respective Welfare Program.
- (e) **“Claims Administrator”** means the insurance company, third party administrator or other entity designated by the Plan Administrator to determine benefit eligibility and availability and/or pay claims and decide appeals for benefits under this Plan or any Welfare Program under this Plan.
- (f) **“Code”** means the Internal Revenue Code of 1986, as amended.

- (g) **“Company”** means Fluor Federal Services Inc. In the event of a reorganization, merger or similar transaction affecting the Company, any successor entity may adopt the Plan for the benefit of Employees of such successor, in which event, the Plan shall continue without any gap or lapse in coverage.
- (h) **“Dependent”** means a covered Dependent under the Plan as defined under the terms of the respective Welfare Program, regardless of the actual tax treatment of benefits provided to such individual pursuant to the Code. “Dependent” may include an Employee’s or Former Employee’s Spouse, Children, Domestic Partner, or the Children of a Domestic Partner if covered under the terms of the respective Welfare Program.
- (i) **“Domestic Partner”** means a Domestic Partner under the Plan as defined under the terms of the respective Welfare Program.
- (j) **“Effective Date”** for the Plan means October 1, 2015, the amendment and restatement date of this Plan. The original effective date is October 20, 2014.
- (k) **“Employee”** means, unless otherwise specified in a Welfare Program, any person currently employed by the Employer who is receiving compensation for services performed and who is classified by the Employer as eligible to participate in a Welfare Program. Employees on certain leaves of absence are also eligible to participate in the Plan, subject to additional terms and conditions as specified in Article XI. “Employee” shall not include any person classified on the Employer’s records as other than an employee. For example, “Employee” shall not include anyone classified on the Employer’s records as an independent contractor, agent, leased employee, or similar classification, regardless of any subsequent or retroactive reclassification or determination by a governmental agency that any such person is a common law employee of an Employer, unless otherwise required by law. Notwithstanding anything to the contrary contained herein or in the Welfare Programs, Employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be eligible to participate in the Plan.
- (l) **“Employer”** means the Company, and any other entity within the controlled group that may participate in the Plan with the approval of the Plan Administrator. The Plan Administrator shall have the right to terminate any Employer’s adoption of the Plan at any time. If an Employer merges or is otherwise consolidated with any affiliate of the Company, the successor shall, as to the group of Employees covered by the Plan immediately before such merger or consolidation, be the Employer as defined hereunder, unless the Plan Administrator specifies to the contrary. In case of any other merger or consolidation, the successor shall not be the Employer except to the extent that it acts to adopt the Plan with the approval of the Plan Administrator and pursuant to applicable law.
- (m) **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.

- (n) **“Former Employee”** means any person formerly employed as an Employee of the Employer.
- (o) **“Participant”** means an Employee or Former Employee of the Employer who meets the requirements for eligibility as set forth in Article II and who properly enrolls in the Plan. A person shall cease to be a Participant when he or she no longer meets the requirements for eligibility as set forth in Article II, except as provided in Article X.
- (p) **“Participant Contribution”** means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term “Participant Contribution” includes contributions used for the provision of benefits under a self-funded arrangement of the Company or an Employer as well as contributions used to purchase insurance contracts or policies.
- (q) **“Plan”** means this Plan, the Fluor Federal Services, Inc. Paducah Deactivation Project Health & Welfare Plan, which consists of this document, and each Welfare Program incorporated hereunder by reference, as amended from time to time.
- (r) **“Plan Administrator”** shall have the same meaning as set forth in ERISA Section 3(16). The Plan Administrator for the Plan shall be the Benefits Committee, unless another entity or person is appointed by the President/Program Manager to administer the Plan pursuant to Section 7.1 of this Plan.
- (s) **“Plan Year”** means an initial Plan Year commencing on October 20, 2014 and ending September 30, 2015, a short Plan Year commencing on October 1, 2015 and ending December 31, 2015, and each subsequent twelve (12) consecutive month period commencing on January 1 and ending on December 31.
- (t) **“SPD”** means any Summary Plan Description, Summary of Material Modifications or other Employee communication that describes the benefits under a Welfare Program, and has been designated by the Company and/or Employer as part of this Plan.
- (u) **“Spouse”** means the legal spouse (as defined by Federal law) of a Participant.
- (v) **“Welfare Program”** means a Welfare Program Document incorporated into this Plan that is sponsored by the Company and/or an Employer that provides any Employee or Former Employee a benefit that would be treated as an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 of the Code, if incorporated herein. Each Welfare Program under the Plan is identified in Appendix A. The Plan Administrator may add a Welfare Program or delete a Welfare Program from the Plan by amending Appendices A and B, without any need to otherwise amend the Plan. Amendment of Appendices A and B may be made by the Plan Administrator or any authorized member or representative of the Plan Administrator and shall not require formal approval by the Board of Managers. All Welfare Program Documents under the Plan are contained in Appendix B.

- (w) **“Welfare Program Document”** means a plan document or other instrument under which a Welfare Program is established and operated.

**Section 1.4 Interpretation.**

The Plan shall consist of the articles and appendices of this Plan document as well as the Welfare Program Documents for the Welfare Programs identified in Appendix A and contained in Appendix B. If a provision of the articles of this Plan document or an SPD directly conflicts with the provisions of an insured Welfare Program Document, the provision of the relevant Welfare Program Document shall control, except as otherwise expressly stated in this Plan or the SPD.

Notwithstanding the foregoing, if there is a conflict between the provisions of any of the articles of this Plan document, a Welfare Program Document or an SPD of a Welfare Program Document, and such conflict involves a provision required by ERISA or the Code on the one hand, and a provision not so required on the other, the provision required by ERISA or the Code shall control. The terms of this Plan document may not enlarge the rights of a Participant, Dependent or Beneficiary to benefits available under the Welfare Program Document of the applicable Welfare Program.

## **ARTICLE II ELIGIBILITY AND PARTICIPATION**

### **Section 2.1 Eligibility.**

An Employee or Former Employee shall be eligible to participate in the Plan only if and to the extent the Employee or Former Employee is eligible with respect to the particular benefit in question under a Welfare Program specified in Appendix A. The Welfare Programs also designate those Dependents or Beneficiaries, if any, of an Employee or Former Employee who are eligible to receive benefits from the Plan and set forth the criteria for their becoming covered thereunder.

### **Section 2.2 Enrollment.**

The Plan Administrator may establish procedures in accordance with the Welfare Programs for the enrollment of Employees and Former Employees (and/or their Dependents) under the Plan. The Plan Administrator may prescribe enrollment processes that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

### **Section 2.3 Commencement of Participation**

An Employee or Former Employee and his or her Dependents shall commence participation in the Plan as of the later of: (i) the Effective Date; or (ii) the date the Employee or Former Employee becomes a Participant in any of the Welfare Programs identified in Appendix A of this Plan, provided the Employee or Former Employee has otherwise satisfied the requirements of Section 2.2 during the applicable enrollment period.

### **Section 2.4 Termination of Participation.**

A Participant will cease being a Participant in the Plan, and coverage under this Plan for the Participant and his Dependents and Beneficiaries shall terminate in accordance with the provisions of the specific Welfare Program.

Participation in the Welfare Programs is subject to prospective and retroactive termination in the event of fraud or intentional misrepresentation of a material fact.

## **ARTICLE III FUNDING**

### **Section 3.1 Funding.**

Notwithstanding anything to the contrary contained herein, participation in the Plan by a Participant and the payment of Plan benefits attributable to Company or Employer contributions shall be conditioned on such Participant Contributions to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time. The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Company, an Employer, or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Dependent or Beneficiary, except to the extent specifically required under the terms of a Welfare Program or applicable law. No Participant, Dependent or Beneficiary shall have any right to, or interest in, the assets of the Company or any Employer.

Benefits or premiums for this Plan shall be funded through the general assets of the Employer or insurance contracts in accordance with the terms of the relevant Welfare Program. The Company shall have no obligation, but shall have the right, to insure any Welfare Program under this Plan. To the extent the Company elects to purchase insurance with respect to this Plan, payment of any benefits under such Welfare Program shall be the sole responsibility of the insurer, and the Company and the Employers shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer).

**ARTICLE IV**  
**BENEFITS**

**Section 4.1 Benefits.**

Notwithstanding anything to the contrary contained herein, benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

**ARTICLE V**  
**CLAIMS, COORDINATION OF BENEFITS, SUBROGATION AND**  
**REIMBURSEMENT**

**Section 5.1 Claims Procedure.**

- (a) Except as provided in subsection (b), a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program. Notwithstanding the foregoing, unless a Welfare Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises (i.e., the date a medical service is provided and the charge is incurred). In the event that a claim, as originally submitted, is not complete, the Claimant may be notified and the Claimant shall then have the responsibility for providing the missing information within the timeframe stated in such notification.
- (b) In the event that: (1) a Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (2) the Plan Administrator (or its designated Claims Administrator) determines that the procedures described in subsection (a) with respect to a particular Welfare Program shall not apply, the claims procedure described below shall apply.
- (c) The claims procedures applicable to claims made for benefits under this Plan do not apply to casual or general inquiries regarding eligibility or particular Welfare Program benefits that may be provided under the Plan. In order for an inquiry to constitute a claim for benefits or an appeal of a denial of a claim for benefits, the Participant, Dependent or Beneficiary must follow the claim procedures under the applicable Welfare Program, or, if such procedures are not contained in such Welfare Program, then according to the reasonable procedures under this Plan.
- (d) For purposes of determining the amount of or entitlement to benefits of a Welfare Program provided under insurance or contracts, the respective insurer or Health Maintenance Organization (“HMO”) is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract. To obtain benefits from the insurer or HMO of a Welfare Program, a Claimant must follow the claims procedures under the applicable insurance or HMO contract, which may require a Claimant to complete, sign and submit a written claim on the insurer’s or HMO’s form.

The insurer or HMO will decide a claim in accordance with its reasonable claims procedures, as required by ERISA. The insurer or HMO has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the insurer or HMO denies a claim, in whole or in part, a Claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, a Claimant may appeal to the insurer or HMO for a review of the denied claim. The insurer or HMO will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA.

- (e) For purposes of determining the amount of or the entitlement to benefits under a Welfare Program provided through a self-funded arrangement, the Plan Administrator (or its designated Claims Administrator) is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

The Plan Administrator (or its designated Claims Administrator) will decide a claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator (or its designated Claims Administrator) has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the Plan Administrator (or its designated Claims Administrator) denies a claim, in whole or in part, a Claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Claimant may appeal to the Plan Administrator (or its designated Claims Administrator) for a review of the denied claim. The Plan Administrator (or its designated Claims Administrator) will decide the Claimant's appeal in accordance with reasonable claims procedures, as required by ERISA.

### **Section 5.2 Definitions.**

For the purposes of this Article V, the following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein.

- (a) “**Claimant**” means a Participant, Dependent or Beneficiary under the Plan, or his representative or health care provider, who is designated by such individual to act on his behalf.
- (b) “**Complete Claim**” means a claim that contains all of the necessary information and supporting documentation, if applicable, to render a decision on the claim and is submitted within the prescribed timeframe under the Plan's reasonable claims procedures.
- (c) “**Concurrent Care Claim**” means: (1) a claim to continue a previously approved course of treatment under a group health plan for a specific time period or number of treatments that has been reduced or terminated before the end of the approved course of treatment or (2) to continue a course of treatment beyond the specific time period or number of treatments previously approved under a group health plan. A Concurrent Care Claim may be for urgent or non-urgent healthcare. Notwithstanding the foregoing, a group health benefit for an ongoing course of treatment that has been reduced or terminated as a result of Plan termination or amendment will not be considered a claim.

- (d) **“Disability Claim”** means a claim for a disability benefit under a disability insurance plan or the Plan.
- (e) **“Group Health Claim”** means a claim for group health benefits that is either a Post-Service Claim, a Pre-Service Claim or a Concurrent Care Claim.
- (f) **“Other Claim”** means a claim for a benefit under a Welfare Program or the Plan that does not involve a Group Health Claim or Disability Claim.
- (g) **“Post-Service Claim”** means a claim for a benefit under a group health plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a claim that is not either a Pre-Service Claim, a Concurrent Care Claim or an Urgent Care Claim.
- (h) **“Pre-Service Claim”** means a claim for a benefit under a group health plan that, under the terms of the applicable group health plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.
- (i) **“Urgent Care Claim”** means a claim for medical care or treatment that, if not received, could jeopardize the Claimant’s health or life, the ability to regain function at a maximum level or subject the Claimant to severe pain. If a health care provider with knowledge of the Claimant’s medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim.

**Section 5.3 Initial Claim Procedure and Time Limits.**

- (a) Initial Claim Process. A claim and all required documentation shall be filed in writing with the applicable Claims Administrator and decided within the applicable timeframe under Federal law, regardless of whether or not all information required to perfect the claim is included. The timeframe for decision begins upon receipt of the claim by the Claims Administrator and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim. The Claims Administrator may not suspend a claim on the basis that the claim submission is incomplete.
- (b) Urgent Care Claim:
  - i. If an Urgent Care Claim as submitted is complete, the Claims Administrator will render a decision within seventy-two (72) hours of the time the Complete Claim is received.
  - ii. If an Urgent Care Claim as submitted is incomplete, the Claims Administrator will notify the Claimant within twenty-four (24) hours of receiving the incomplete claim. Such notice will request additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded forty-eight (48) hours to provide the requested

information. The Claims Administrator will make its decision not later than: (i) forty-eight (48) hours after the Plan's receipt of the requested information or (ii) the end of the period given to the Claimant to provide the information, whichever is earlier.

- iii. Notice of the claim decision shall be furnished promptly to the Claimant. The notice shall be written in a manner understandable to the Claimant or may be made orally, if followed by a written notice within three (3) days of such oral notice. The notice will contain applicable notification information as required by Federal law. An extension of the seventy-two (72) hour decision deadline may be made only upon consent of the Claimant.

(c) Pre-Service Claim:

- i. If a Pre-Service Claim as submitted is complete, the Claims Administrator will render a decision within fifteen (15) days of the time the Complete Claim is received. The Claims Administrator may extend this time period by fifteen (15) additional days if the Claimant is notified of the need for such extension before the expiration of the initial fifteen (15) day decision period. Notification of the extension shall include the reason for the extension, an approximate decision date and other applicable notification information as required under Federal law.
- ii. If a Pre-Service Claim as submitted is incomplete, the Claims Administrator may notify the Claimant within five (5) days of receiving the incomplete claim. Such notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the fifteen (15) day time period to render a decision. The Claimant shall be afforded forty-five (45) days to provide the requested information. If the requested information is not received within this time period, then the Claims Administrator will render a decision at the end of the forty-five (45) day period. If the requested information is received before the end of the forty-five (45) day period, the suspension of the initial fifteen (15) day claim determination period shall be lifted and the Claims Administrator will render a decision within the time remaining of the initial fifteen (15) day decision period, subject to permissible extension.
- iii. Notice of a claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant and shall contain applicable notification information as required under Federal law.

(d) Post-Service Claim:

- i. If a Post-Service Claim as submitted is complete, the Claims Administrator shall render a decision within thirty (30) days of the time the Complete Claim is received. The Claims Administrator may extend this time period by fifteen (15) additional days, if the Claimant is notified of the need for such extension before the expiration of the initial thirty (30) day decision period. Notification of the

extension shall include the reason for the extension, an approximate decision date and other applicable notification information as required under Federal law.

- ii. If a Post-Service Claim as submitted is incomplete, the Claims Administrator may notify the Claimant within thirty (30) days of receiving the incomplete claim. Such notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the thirty (30) day time period to render a decision. The Claimant shall be afforded forty-five (45) days to provide the requested information. If the requested information is not received within this time period, then the Claims Administrator will render a decision at the end of the forty-five (45) day period. If the requested information is received before the end of the forty-five (45) day period, the suspension on the time frame for decision is lifted and the Claims Administrator will render a decision within the time remaining of the initial thirty (30) day period, subject to permissible extension.
- iii. If a Post-Service Claim is denied, notice of the claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant and shall contain applicable notification information as required under Federal law.

(e) Urgent Concurrent Care Claim:

- i. If an Urgent Concurrent Care Claim requesting an extension of a course of treatment that is considered Urgent Care is submitted more than twenty-four (24) hours before the end of the previously approved course of treatment, the Claims Administrator shall render a decision within twenty-four (24) hours of the time the claim is received.
- ii. If an Urgent Concurrent Care Claim requesting an extension of a course of treatment that is considered Urgent Care is submitted less than twenty-four (24) hours before the end of the previously approved course of treatment, the claim will be treated as a Complete Urgent Care Claim and a decision will be rendered within seventy-two (72) hours. An extension of the seventy-two (72) hour decision deadline may be made only upon consent of the Claimant.
- iii. If any Urgent Concurrent Care Claim as submitted is incomplete, the claim shall be handled in accordance with the procedures applicable to incomplete Urgent Care Claims as described in subsection (b).
- iv. Notice of a claim decision on an Urgent Concurrent Care Claim shall be furnished promptly to the Claimant. The notice shall be written in a manner understandable to the Claimant or may be made orally, if followed by a written notice within three (3) days of such oral notice. Such notice shall contain applicable notification information as required under Federal law.

(f) Non-Urgent Concurrent Care Claim:

- i. If a Non-Urgent Concurrent Care Claim requesting an extension of a course of treatment that does not require preauthorization is submitted, the Claims Administrator shall render a decision according to the Post-Service Claim procedures under subsection (d).
- ii. If a Non-Urgent Concurrent Care Claim requesting an extension of a course of treatment that requires pre-authorization is submitted, the Claims Administrator shall render a decision according to the Pre-Service Claim procedures under subsection (c).
- iii. In the event a Claimant's pre-approved course of treatment for a specific time period or specific number of treatments is reduced or terminated before the end of such treatment, the Claimant must be notified of the reduction or termination by the Claims Administrator and be given a reasonable period of time to appeal the decision before the treatment is reduced or eliminated. The Claims Administrator shall render a decision before the previously approved treatment is reduced or terminated.

(g) Disability Claim:

- i. If a Disability Claim as submitted is complete, the Claims Administrator shall render a decision within forty-five (45) days of the time the claim is received.
- ii. The Claims Administrator may under special circumstances extend this time period by thirty (30) additional days if the Claimant is notified of the need for such extension before the expiration of the initial forty-five (45) day period. The Claims Administrator may under special circumstances extend the initial extension period by an additional thirty (30) days if the Claimant is notified of the need for such additional extension before the expiration of the initial thirty (30) day extension. Notification of any extension shall include the reason for the extension, an approximate decision date, and other applicable notification information as required under Federal law.
- iii. If a Disability Claim as submitted is incomplete, the Claims Administrator may notify the Claimant within forty-five (45) days of receiving the incomplete claim. The notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the forty-five (45) day time period to render a decision, and the Claimant shall be afforded forty-five (45) days to provide the requested information. Subject to the Claim Administrator's ability to extend the decision period as described in subparagraph (ii), if the requested information is not received within this time period, then a decision will be rendered at the end of the initial forty-five (45) day period, and if the requested information is received before the end of the forty-five (45) day period, the suspension on the time frame for decision is lifted and a

decision will be rendered within the time remaining of the initial forty-five (45) day period, subject to permissible extension.

- iv. Notice of a claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant, and shall contain applicable notification information as required under Federal law.

(h) Other Claims:

- i. Unless otherwise provided in the preceding subparagraphs, the Claims Administrator shall render a decision on a claim within ninety (90) days from the time the claim is received. The Claims Administrator may, under special circumstances, extend this time period by ninety (90) additional days if the Claimant is notified of the need for such extension before the expiration of the initial ninety (90) day decision period. Notification of any extension shall include the reason for the extension and an approximate decision date.
- ii. If the claim is denied, notice of such decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant, and shall contain applicable notification information as required under Federal law.

**Section 5.4 Notification of Initial Claim Decision.**

- (a) Upon making a claim determination, the Plan Administrator (or its designated Claims Administrator) shall provide the Claimant with written or electronic notice of the claim determination to the extent required under Federal law, that includes those items listed in (b)(i) to (b)(vii), as applicable and shall be written in a manner calculated to be understood by the Claimant. With respect to Urgent Care Claims, notice of the decision may be given orally, provided such notice includes those items listed in subsections (b)(i) through (b)(viii), and provided the Plan Administrator (or its designated Claims Administrator) gives written notice including all of the information described in subparagraph (b) within three (3) days of such oral notification.
- (b) Notice provided to a Claimant shall contain the following information:
  - i. The specific reason(s) for the denial;
  - ii. A reference to the specific Plan and/or SPD provisions upon which the denial was based;
  - iii. 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 (if applicable);
  - iv. A description of the appeal procedures and the time limits applicable to appealing the claim decision;

- v. A statement of the Claimant's right to bring legal action under ERISA;
- vi. An explanation of any rule, protocol, procedure or guideline upon which the denial was based or a statement that explains the Claimant's right to receive a copy of such information free of charge upon request; and
- vii. If the denial was based on medical necessity, experimental treatment or other similar exclusion or limit, the notice shall contain either:
  - (A) An explanation of the clinical or scientific judgment for making such decision, applying the terms of the Plan to the Claimant's medical condition, or
  - (B) A statement that such explanation is available free of charge upon request.
- viii. For Urgent Care Claims only, information regarding the expedited appeal process applicable to such claim.

**Section 5.5 Appeal Procedures.**

- (a) Commencement of Appeals/Disclosure of Information.
  - i. In the event a Claimant's initial claim for benefits is wholly or partially denied, the Claimant or his or her duly authorized representative may voluntarily request a review on appeal by the Plan Administrator of the denial. The Claimant must complete all of the administrative review steps available through the Claim Administrator before an appeal to the Plan Administrator is permitted under this Plan.
  - ii. Written requests for review of a denied Group Health Claim or Disability Claim on review must be made within one-hundred eighty (180) days of the adverse claim decision (sixty (60) days for Other Claims) and must include the Claimant's name and identification number from the ID card; the date(s) of service(s), as applicable; the provider's name, as applicable; a copy of the denial letter(s); and the basis of the appeal. The Claimant may submit additional comments, documents, records and other materials with his or her written request for appeal.
 

Notwithstanding the foregoing, a Claimant may request an expedited appeal of an Urgent Care Claim either orally or in writing, and may submit all of the necessary information via telephone, facsimile or other similarly expeditious method.
  - iii. The Plan Administrator (or its designated Claims Administrator) shall provide the Claimant with reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim. "Relevant Information" means information: (A) relied upon in the initial benefit claim determination, (B) submitted, considered or generated in the course of the initial benefit claim determination, or (C) that constitutes a statement of policy or guidance with

respect to the plan concerning the denial, regardless of whether it was relied upon in making the benefit determination, and (D) that demonstrates compliance with the administrative processes and safeguards required in making the determination.

- iv. If a medical or vocational expert was consulted in connection with the Claimant's initial claim, the expert's name will, upon request by the Claimant, be disclosed to the Claimant, regardless of whether the expert's opinion was used to render the initial claim decision. If a medical or vocational expert is consulted during the course of the appeal, the expert consulted on appeal shall be different than, and not a subordinate of, the expert consulted during the initial claim process.
- v. A claim on appeal will be given a full and fair review by the Plan Administrator (or its designated Claims Administrator) and shall include a review of all materials used to reach the initial claim decision; however, deference shall not be given to the initial claim decision, nor shall the same fiduciary that made the initial claim decision review the appeal. The fiduciary on appeal shall not be a subordinate of the fiduciary who made the initial claim decision. A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination.

(b) Deadlines for Decision on Appeal.

- i. Upon timely receipt of a Claimant's request for review on appeal (including an appeal of a Concurrent Care Claim), the Plan Administrator (or its designated Claims Administrator) will evaluate the claim and make a final determination within the following determination periods, which shall begin to run upon the Plan Administrator's (or designated Claims Administrator's) receipt of the appeal (regardless of whether or not all information required to perfect the claim is included in the Claimant's request for review on appeal):

<b><u>Type of Claim</u></b>	<b><u>Appeals Determination Period</u></b>
Urgent Care Claim	72 Hours
Pre-Service Claim	30 Days
Post-Service Claim	60 Days
Disability Claim	45 Days
Other Claim	60 Days

- ii. With respect to Concurrent Care Claims, if an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Claimant's request to extend the treatment is an Urgent Care Claim as defined above, the Claimant's request will be decided within 24 hours, provided the Claimant's request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on the Claimant's request for the extended treatment within 24 hours from receipt of the

Claimant's request. If the Claimant's request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Claimant requests to extend treatment in a non-urgent circumstance, the Claimant's request will be considered a new claim and decided according to Post-Service or Pre-Service claim timeframes, whichever applies.

- iii. The Plan Administrator (or its designated Claims Administrator) may not extend the time period for decision on a Group Health Claim appeal unless the Claimant voluntarily agrees to such extension.
- iv. Notwithstanding the foregoing, with respect to Disability Claims and Other Claims only, the Plan Administrator (or its designated Claims Administrator), under special circumstances, may extend the appeals determination period by a number of days equal to the number of days included in the initial appeals determination period, provided the Claimant is notified of the extension prior to the end of the initial appeals determination period, and the Plan Administrator includes in such notice the reason for the extension and an estimate of the date on which the appeal determination will be made.

(c) Notice of Determination on Appeal:

Upon making a claim determination, the Plan Administrator (or its designated Claims Administrator) shall provide the Claimant written or electronic notice of the claim determination, which shall be written in a manner calculated to be understood by the Claimant, and which shall contain the following applicable information:

- i. The specific reason(s) for the denial;
- ii. A reference to the specific Plan and/or SPD provisions upon which the denial was based;
- iii. A statement that the Claimant is entitled to receive, free upon request, copies of and reasonable access to documents, records and other information relevant to the claim;
- iv. A statement describing any voluntary appeal procedure, if available, and the right to obtain information regarding such procedure, as well as a statement of the Claimant's right to bring legal action under ERISA;
- v. An explanation of any rule, protocol, procedure or guideline upon which the denial was based or a statement that explains the Claimant's right to receive a copy of such information free of charge upon request; and

- vi. If the denial was based on medical necessity, experimental treatment or other similar exclusion or limit, the notice shall contain either:
  - (A) An explanation of the clinical or scientific judgment for making such decision, applying the terms of the plan to the Claimant's medical condition, or
  - (B) A statement that an explanation is available free of charge upon request.

**Section 5.6 Additional Procedures for Medical Claims.**

- (a) For purposes of this section:
  - i. "Medical Program" means a Welfare Program that provides group health benefits that are subject to the Patient Protection and Affordable Care Act.
  - ii. "PHS Act" means the Public Health Service Act.
- (b) If and to the extent required by PHS Act §2719 in connection with a Medical Program:
  - i. Notice of an adverse benefit determination or a final internal adverse benefit determination will include information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount, and a statement as to the availability of the diagnosis code (and meaning) and treatment code (and meaning).
  - ii. Notice of claims and appeals determinations will be provided in a culturally and linguistically appropriate manner.
  - iii. A Claimant will be permitted to present written evidence and written testimony in connection with an appeal.
  - iv. In connection with an appeal, the Plan will provide the Claimant, free of charge:
    - (A) any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; and
    - (B) any new or additional rationale that will be a basis for final internal adverse benefit determination.The evidence and rationale must be provided as soon as possible and sufficiently in advance of the final internal adverse decision so as to give the Claimant a reasonable opportunity to respond prior to that date.
  - v. A rescission of coverage will be treated as an adverse claim determination and subject to appeal as a Post-Service Claim.

- vi. The Plan will arrange for external review of adverse decisions on final appeal if requested by the Claimant within four months of the decision on final appeal and provided that the adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan. For Urgent Care Claims, the Claimant may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited internal appeal.
- (c) The Claims Administrator may modify the procedures and timeframes specified in this Section to comply with the minimum requirements of PHS Act §2719 as from time to time interpreted by the Department of Labor.

**Section 5.7 Action for Recovery.**

Unless stated otherwise under the individual terms of a Welfare Program, no action at law or in equity may be brought for recovery under this Plan prior to exhaustion of the mandatory claims procedures set forth in this Article V. Under no circumstances may any claim for recovery under this Plan, including any lawsuit, be made later than one (1) year from the time written proof of a claim is required to be furnished.

**Section 5.8 Participant's Responsibilities.**

Each Participant shall be responsible for providing the Plan Administrator and/or the Company with the Participant's, Dependent's and each Beneficiary's current U.S. mailing address and/or electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the individual and mailed either by regular United States mail or by electronic means as specified in Section 2520.104b-1(c) of ERISA. The Plan Administrator, the Company and the Employer shall not have any obligation or duty to locate a Participant, Dependent or Beneficiary. In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

- (a) because the current address according to the Company's records is incorrect;
- (b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Company's records;
- (c) because of conflicting claims to such payments; or
- (d) for any other reason,

the amount of such payment, if and when made, shall be determined under the provisions of this Plan without payment of any interest, earnings or consequential damages.

**Section 5.9 Unclaimed Benefits.**

If, within twelve (12) months after any amount becomes payable hereunder to a Participant, Dependent or Beneficiary, and the same shall not have been claimed or any check issued under the Plan remains not cashed, provided reasonable care shall have been exercised in attempting to make

such payments, the amount thereof may be forfeited and shall cease to be a liability of the Plan, subject to applicable law.

**Section 5.10 Coordination of Benefits.**

- (a) Coordinating Benefits with Coverage from Another Source - If a Participant, Dependent or Beneficiary has coverage under this Plan as well as Coverage from Another Source, benefits that are received through this Plan shall be coordinated with the benefits available under the plan containing the Participant's, Dependent's or Beneficiary's other source of benefits. This coordination of benefits ("COB") provision shall apply to all health benefits provided under this Plan.
  
- (b) Coverage from Another Source - For purposes of this Article V, "Coverage from Another Source" shall mean any other plan providing benefits or services for medical treatment, including but not limited to, one of the following:
  - i. group insurance, or any other arrangement of coverage for individuals in a group Health Maintenance Organization ("HMO") or other group on an insured, self-insured or uninsured basis, or state or Federal programs providing health coverage;
  - ii. group coverage sponsored through a school or other educational institution, for a student;
  - iii. group coverage under franchise organizations; or
  - iv. no-fault insurance required under any law of a government and provided on other than a group basis, but only to the extent the benefits are required under such no-fault law.
  
- (c) Construction - Coverage from another source will be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will, for purposes of this Article V, be considered to be both a covered charge and the amount of benefit paid.

- (d) Ordering of Benefits - When coverage is provided by two or more sources as stated above, the plan that is primary is established in the following order:
  - i. The plan that has no COB provision will be considered primary to a plan that has COB provisions;

- ii. The plan that has a COB provision, except that such COB provision is not similar to this Plan's COB provision, shall be considered primary to this Plan which has a COB provision;
- iii. The plan covering the person as an Employee will be primary to the plan covering the person as a Dependent;
- iv. The plan covering a person in his/her own capacity will be primary to the plan covering a person as a Dependent; however, if the person is a Medicare Beneficiary, and Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as a non-Dependent, then the plan covering the person as a Dependent is primary, Medicare is secondary and the plan covering the person as a non-Dependent is the tertiary plan (that is, in this specific situation, the plan covering the person as a non-Dependent pays only after the plan covering the person as a Dependent and after Medicare);
- v. The plan covering a person as an active Employee will be primary to the plan covering the person as a retired, terminated, inactive, suspended or laid-off Employee;
- vi. The plan covering a Dependent as a Dependent of an active Employee is primary to the plan covering the Dependent as the Dependent of a former Employee or as a COBRA Participant;
- vii. For the purposes of a Dependent covered under the plans of both of his or her non-divorced parents (or parents who never married, but who live together) the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, then the plan covering the parent for the longest period of time will be primary; or
- viii. For a Dependent whose parents are divorced or legally separated (or if the parents never married and do not live together), and the Dependent is covered by the plans of both parents, the plan covering the parent who is responsible for the Dependent's health care under the terms of a court decree or state agency order will be the primary payor. In the absence of such court decree or state agency order payment will be made in the order as follows:
  - (A) the plan of the natural parent with custody;
  - (B) the plan of the step-parent with custody; and
  - (C) the plan of the natural parent without custody.
- ix. if (i), (ii), (iii), (iv), (v), (vi), (vii) or (viii) do not apply, then the plan covering the person for the longest period of time will be primary.

- (e) Reduction of Benefits Payable By the Plan - Whenever this Plan is considered secondary to another plan, benefits will be payable by the primary plan to the extent that the expense is an incurred charge, and this Plan shall be liable for the remainder of the eligible expenses that would be payable in the absence of dual coverage up to the amount that would otherwise be payable to the extent payable in total under this Plan.
- (f) Coordination of Benefits for Persons Eligible for Medicare - The above provisions of this Section 5.10 shall apply to Participants and Dependents eligible for Medicare, subject to the following provisions.
  - i. This Plan is a primary plan with regard to the following Participants and Dependents eligible for Medicare:
    - (A) An Employee who is age sixty-five (65) or older;
    - (B) A Spouse, age sixty-five (65) or older, of an Employee of any age;
    - (C) Participants and Dependents entitled to Medicare solely on the basis of end-stage renal disease (“ESRD”), in which case this Plan is a primary plan only for the first thirty (30) months (or such other coverage period as provided by law) of Medicare eligibility (not entitlement) under Section 226A(b)(1)(B) of the Social Security Act or as otherwise required by applicable law; and
    - (D) Disabled active Employees and disabled Dependents of active Employees as specified in Section 1862(b)(4)(A) of the Social Security Act. “Active Employee” shall be given the same meaning as specified under the Omnibus Budget Reconciliation Act of 1993.
  - ii. This Plan is a secondary plan with regard to all other Participants and Dependents eligible for Medicare to the extent permitted by law.
  - iii. For Employees and/or Spouses of Employees, age sixty-five (65) or older, with coverage under the Plan, Medicare will be the secondary payor for such individual for as long as the Employee remains actively employed with the Employer.
  - iv. Coverage under the Plan which is provided to Domestic Partners and Children of Domestic Partners will be coordinated with Medicare in accordance with this subsection and applicable law.

**Section 5.11 Right of Subrogation and Reimbursement.**

If a Participant or Dependent becomes entitled to benefits under a Welfare Program as a result of an injury or illness for which a third party is, or may be, held responsible for any reason, the Plan may: (1) make full or partial advance benefit payments to, or payments on behalf of, such

Participant or Dependent, subject to the Plan's subrogation and reimbursement rights; or (2) may delay payment of all or part of such benefits and either pay such benefits or require the third party to pay such benefits upon settlement or judgment. However, before any such reimbursements or payments will be conditionally made, the Participant or Dependent shall execute a subrogation and reimbursement agreement acceptable to the Plan that acknowledges and affirms: (1) the conditional nature of the reimbursements or payments; and (2) the Plan's rights of subrogation and reimbursement, as provided for below. However, payment by the Plan of any benefits prior to or without obtaining a signed subrogation and reimbursement agreement shall not operate as a waiver of the Plan's subrogation and reimbursement rights.

If a Participant or Dependent receives any benefits arising out of an injury or illness for which the Participant or Dependent has or may have, or asserts any claim or right to recovery against a third party or parties, third-party insurance or first-party insurance, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Participant or Dependent to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant or Dependent or recovered by the Participant or Dependent from: (1) any policy or contract from any insurance company or carrier (including the Participant's or Dependent's insurer and specifically including the Participant's or Dependent's own or any other person's uninsured/under-insured automobile coverage, medical pay, personal injury protection or no fault benefits); and/or (2) any third party, plan or fund as a result of a judgment, settlement or otherwise. The Participant or Dependent acknowledges and agrees that this Plan will be reimbursed in full before any amounts (including attorney fees incurred by the Participant) are deducted from the gross policy proceeds, judgment or settlement.

Any recovery the Participant or Dependent (or his attorney, assign, legal representative, Dependent or Beneficiary) receives shall be held in constructive trust for the benefit of the Plan, to the extent of the Plan's prior payments or provision of benefits. The Plan also has the right to withhold future payments and provisions of benefits and offset future obligations (whether or not related to the injury or illness in question) against any benefits for which the Participant or Dependent has received a third party recovery (whether or not already paid or provided by the Plan). As part of the Plan's subrogation and reimbursement rights, any recovery from a third party will be applied first to reimburse the Plan (or discharge its obligation for future payments or benefits), even if the Participant or Dependent is not paid for all of his or her claim for damages against the third party or otherwise made whole, and even if the payment the Participant or Dependent receives is for, or is described as being for, damages other than health care expenses or benefits paid, provided, or covered by the Plan. This means that any third party payment will be automatically deemed to first cover the medical expenses or benefits previously paid, provided, or otherwise covered by the Plan, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant or Dependent may have incurred, until the Plan is reimbursed in full or otherwise made whole. The Plan's first dollar priority lien means that the Plan must be paid first from any recovery, prior to deduction for attorney's fees. In addition, the Plan is not responsible for a Participant's or Dependent's legal fees, is not required to share in any way for any payment of such fees, and its lien shall not be reduced by any such fees.

In addition, by participating in the Plan and receiving benefits hereunder, the Participant or Dependent automatically grants a lien to the Plan to be impressed upon all rights of recovery against any other parties described above. To perfect this lien, the Plan Administrator may file a copy of a subrogation and reimbursement agreement (signed by the Participant, and if applicable, signed by the Dependent or on behalf of the Dependent) with such other parties, or the Plan Administrator may notify any other parties of the existence of the lien.

This Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity, including, but not limited to, third parties and insurance companies and carriers (including the Participant's or Dependent's own insurer). The amount of such subrogation and reimbursement will equal the total amount paid under this Plan arising out of the injury or illness for which the Participant or Dependent has or may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees and other expenses incurred in enforcing its subrogation and reimbursement rights under this Section 5.11.

The Participant or Dependent specifically agrees to do nothing to prejudice this Plan's rights to reimbursement or subrogation. In addition, the Participant or Dependent agrees to cooperate fully with the Plan in asserting and protecting the Plan's subrogation and reimbursement rights. The Participant or Dependent on behalf of him or herself agrees to execute and deliver all instruments and papers (in their original form) including a subrogation and reimbursement agreement and do whatever else is necessary to fully protect this Plan's subrogation and reimbursement rights. By participating in the Plan, the Participant or Dependent automatically agrees to all the terms of this Section 5.11 and of the subrogation and reimbursement agreement.

Should a Participant or Dependent make or file a claim, demand, lawsuit or other proceeding against a third party or against the Participant's or Dependent's own first-party insurance coverage, who may be liable for the amount of benefits covered or paid by the Plan, the Participant or Dependent shall, as part of such claim, demand, lawsuit or other proceeding, on behalf of the Plan, also seek payment or reimbursement for the full amount of such benefits covered or paid by the Plan. A Participant or Dependent must notify the Plan Administrator prior to making or filing any such claim, demand, lawsuit or other proceeding. The Plan Administrator may, in its sole discretion, at that time or any other time: (1) instruct the Participant or Dependent to seek, not to seek, or to discontinue seeking payment or reimbursement on behalf of the Plan; and (2) pursue such payment or reimbursement independently in the same or in a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether.

Any compromise or settlement entered into by a Participant or Dependent purporting to reduce or limit the amount of the payment designated as reimbursement for medical or any other expenses covered under the Plan to an amount which is less than the benefits paid or covered by the Plan shall not be effective unless the Plan Administrator consents thereto in writing. The Participant or Dependent specifically agrees to notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation and/or reimbursement rights under this Section 5.11.

For purposes of this Section 5.11, the terms Participant and Dependent shall include, as applicable, the Participant/Dependent and/or the Participant's/Dependent's estate or legal guardian and any legal representative appointed by the Participant/Dependent and, in the case of a minor, shall include and be deemed a reference to a custodial parent of the minor, a legal guardian or a guardian ad litem, as appropriate.

**ARTICLE VI  
AMENDMENTS OR TERMINATION**

**Section 6.1 Right to Amend**

The Plan Administrator (or any person, entity, committee or group duly authorized by the Plan Administrator) shall have the right to make at any time any modification, amendment or amendments to this Plan; however, no amendment shall have any retroactive adverse effect on a Participant (or Dependent or Beneficiary), unless the Plan Administrator determines such amendment is necessary or desirable to comply with applicable law and any applicable notice requirements under the law have been met. Furthermore, any duly authorized person, entity, committee or group shall have the power to amend the Plan to the extent that such amendment will not result in a material increase in the cost of the Plan to the Company and to adopt any amendment as may be required to cause the Plan to comply with applicable law.

**Section 6.2 Right to Terminate**

The Plan Administrator through a formal resolution (or any person, entity, committee or group duly authorized by the Plan Administrator) shall have the authority to terminate the Plan at any time, in whole or in part; but in no event shall such termination prejudice any claim or benefit under the Plan that was incurred but not paid prior to the termination date. In the event of the dissolution, merger, consolidation or reorganization of an Employer, the Plan shall terminate as to such Employer unless the Plan is continued by a successor to such Employer with the consent of the Plan Administrator. An Employer may cease to participate in the Plan with respect to its Employees at any time, provided that the Employer is authorized to do so by the Company.

**ARTICLE VII  
ADMINISTRATION AND FIDUCIARY PROVISIONS**

**Section 7.1 Plan Administrator.**

The President/Program Manager of the Company, pursuant to authority delegated by the Board of Managers, has appointed a Benefits Committee to carry out the administration of the Plan as Plan Administrator. The President/Program Manager may appoint one (1) or more persons to serve on the Benefits Committee. To the extent no such appointment is made, the Company shall be the Plan Administrator. The Plan Administrator shall have overall responsibility for the administration of this Plan. All decisions made by the Plan Administrator (or any other person delegated authority by the Plan Administrator to act in accordance with this Plan) shall be final and conclusive on all Employees and Former Employees, their Spouses, their Dependents, their Beneficiaries and all other persons. The Company may pay all usual and reasonable expenses of administering the Plan, in whole or in part, and any expenses not paid by the Company shall not be the responsibility of the Plan Administrator (unless the Company shall be the Plan Administrator). Neither the Plan Administrator nor any other designated representative of an Employer who is an Employee shall receive any compensation with respect to services hereunder, except as such person may be otherwise entitled to benefits under this Plan.

**Section 7.2 Powers and Duties of the Plan Administrator.**

The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

- (a) to have complete and final sole discretionary authority to administer, enforce, construe and interpret the Plan, including interpretation of all Plan documents, decisions relating to all questions of eligibility to participate and determination of the amount, manner and time of payment of any benefits or covered expenses (including questions of whether or not a claim is a reimbursable claim under this Plan) hereunder and without limitation, the determination of all related or non-related questions and matters that arise under the Plan. All decisions, interpretations and determinations described in this subsection (a) shall be final and conclusive, and there shall be no *de novo* review of any such decision by any court. Any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion;
- (b) to prescribe procedures to be followed by Participants, Dependents and Beneficiaries filing application for benefits;
- (c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;
- (d) to receive from the Employer and from Participants, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;
- (e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

- (f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;
- (g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants, Dependents and Beneficiaries and balances which are payable under this Plan, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it shall select for that purpose and may cause a report of such examination to be made; and
- (h) to appoint individuals to assist in the administration of the Plan and any other agents it deems advisable. The Plan Administrator may delegate to such individual any power or duty imposed upon or granted to it by the Plan.

The Plan Administrator may rely upon the reasonable direction, or information from a Participant, Dependent or Beneficiary relating to such person's entitlement to benefits hereunder as being proper under this Plan and shall not be responsible for any act or failure to act by the Employer, except as otherwise provided by law. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee, Former Employee, Dependent or Beneficiary in any manner for any loss or other event because of such person's participation in this Plan.

**Section 7.3 Outside Assistance and Payment of Expenses.**

- (a) Outside Assistance - The Plan Administrator may engage such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons, as it shall deem advisable.
- (b) Payment of Expenses - The Plan Administrator has the right to pay any Plan expenses out of existing Plan funds that, in the Plan Administrator's discretion, are allowable Plan expenses under ERISA.

**Section 7.4 Delegation of Powers.**

The Plan Administrator may delegate to one or more persons, including the Claims Administrator, all or part of the administrative functions relating to the Plan with all powers necessary to enable it to properly carry out such duties, including administration of claims and appeals under the Plan.

**Section 7.5 Indemnification of Fiduciaries.**

Any Employee of an Employer who is a fiduciary of this Plan or a delegate shall be fully indemnified by the Company and by each participating Employer against all liabilities, costs and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Company) imposed upon such Employee or delegate in connection with any claim, action, suit or proceeding to which it may be a party by reason of being a Plan fiduciary or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes, or is alleged to constitute, a breach of such person's responsibilities in connection with the Plan, unless such act

or failure to act is determined to be due to gross negligence or willful misconduct by the fiduciary or delegate.

**Section 7.6 Complete and Separate Allocation of Fiduciary Responsibilities.**

It is intended that this Article VII shall allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each named fiduciary. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. None of such responsibilities, nor any other responsibility, is intended to be shared by two or more of such fiduciaries unless such sharing shall be provided by a specific provision of the Plan or a written agreement with such fiduciary, if any. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two fiduciaries shall not be deemed to have been assigned a shared responsibility. In such situations, the fiduciary giving the directions is solely responsible for, and shall be deemed the named fiduciary with regard to, said responsibility. The responsibility of the second fiduciary shall be to follow such direction insofar as such direction is proper, on its face, under the Plan and any applicable laws.

**Section 7.7 Disclaimer of Liability.**

Except as otherwise provided under Sections 404 through 409 of ERISA, neither the Company, the Board of Managers, the Plan Administrator, an Employer or the board of directors of an Employer, or other persons acting in the capacity as Plan Administrator, nor any person designated to carry out fiduciary responsibilities pursuant to this Plan, shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of this Plan.

**Section 7.8 Rules and Decisions.**

The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable or appropriate. All rules, procedures and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants, Dependents and Beneficiaries in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, Dependent, Beneficiary, the Employer or the legal counsel of the Employer.

**Section 7.9 Facility of Payment.**

Whenever, in the Plan Administrator's opinion, a person is entitled to receive any payment of a benefit or installment hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Plan Administrator may direct the Employer to make payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Plan Administrator), Dependent, relative, Beneficiary or friend of such person for such person's benefit, or the Plan Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 7.10 and applicable law shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

**ARTICLE VIII  
EMPLOYERS**

**Section 8.1 Adoption and Administration Plan.**

An Employer may adopt this Plan, provided that such adoption is with the approval of the Company. As a condition to adopting the Plan, and except as otherwise provided herein, each Employer shall be deemed to have authorized the Company, the Board of Managers and Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Company, the Board of Managers and the Plan Administrator.

**Section 8.2 Termination of Participation.**

Each Employer may cease to participate in the Plan with respect to its Employees or Former Employees, provided the Employer is authorized to do so by the Company.

**ARTICLE IX  
MISCELLANEOUS**

**Section 9.1 Exclusive Benefit.**

This Plan has been established for the exclusive benefit of Participants, their Dependents and Beneficiaries. Except as otherwise provided herein or by applicable law, all Participant contributions under the Plan may be used only for such purpose.

**Section 9.2 Non-Alienation of Benefits.**

No benefit, right or interest of any Participant, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of the Plan. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant, Dependent or Beneficiary entitled to benefits hereunder. Notwithstanding the foregoing, a Participant, Dependent or Beneficiary may, with consent of the Plan Administrator, and by executing any appropriate forms prescribed by the Plan Administrator (or its designated Claims Administrator), assign payment hereunder to a health care provider to whom the Participant is indebted for covered expenses, in which case payment to such party shall operate as a complete discharge of the Plan's obligation with regard to such benefits.

**Section 9.3 Limitation of Rights.**

Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to:

- (a) give any person any legal or equitable right against the Plan (including any assets of the Plan), the Company or an Employer, except as expressly provided herein or required by law; or
- (b) create a contract of employment with any Employee, obligate the Company or an Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way, including the right of the Company or an Employer to discharge any Employee, with or without cause.

**Section 9.4 Governing Laws and Jurisdiction and Venue.**

To the extent any state laws are not preempted by ERISA or otherwise superseded by other Federal law, the Plan shall be construed and enforced according to the laws of the State of Ohio. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any Welfare Program shall be filed in any Federal court of appropriate jurisdiction in Ohio.

**Section 9.5 Severability.**

If any provision of the Plan (or any Welfare Program) is held invalid or unenforceable as a matter of law, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

**Section 9.6 Construction.**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit or enlarge the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

**Section 9.7 Expenses.**

Any expenses incurred in the administration of the Plan shall be paid by the Plan, by the Company and/or by one or more Employers, according to the Plan Administrator's determination under applicable law, and shall not be the responsibility of the Plan Administrator in such capacity.

**Section 9.8 Overpayments.**

If for any reason, any benefit, premium or fee under this Plan is erroneously paid to a Participant (Dependent or Beneficiary), a provider, insurance company or other related entity for the benefit of a Participant, Dependent or Beneficiary, the Participant (or Dependent or Beneficiary), provider, insurance company or other related entity, in the discretion of the Plan Administrator, shall be responsible for refunding the overpayment to this Plan. The refund shall be a lump-sum payment charged directly to the Participant (or Dependent or Beneficiary), a reduction of the amount of future benefits otherwise payable, or any other legally permissible method which the Plan Administrator shall deem appropriate, including payroll deduction in the case of an Employee or his Dependent (in which case the Employee shall execute such forms authorizing payroll deduction as the Plan Administrator shall request).

**Section 9.9 Entire Plan.**

This Plan document constitutes the entire Plan, and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

**ARTICLE X**  
**COBRA CONTINUATION COVERAGE**

**Section 10.1 Continuation of Benefits Under COBRA.**

Qualified Beneficiaries shall have all continuation rights required by the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) for health benefits offered under Welfare Programs within this Plan. To the extent a Welfare Program offering health benefits does not specify COBRA Continuation Coverage rights in accordance with Code Section 4980B, the Plan shall be administered in accordance with Code Section 4980B and 29 CFR Part 2590.606-1 through 2590.606-4, with respect to the final COBRA notice rules and regulations for group health plans. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 10.1. This Article X is intended to comply with the minimum requirements imposed by COBRA. To the extent any provision in this Article X provides rights greater than those required by COBRA, such provision shall be inapplicable and the minimum-required COBRA provisions shall apply.

Coverage continuation rights similar to those described in this Article may be available to Domestic Partners and Children of Domestic Partners pursuant to the terms of a Welfare Program. Otherwise, the rights and obligations set forth in this Article X would generally not apply to such persons.

**Section 10.2 Election of COBRA.**

COBRA Continuation Coverage for Terminated Employees. In the event a Qualified Beneficiary experiences a Qualifying Event, the Plan Administrator (or its designated Claims Administrator) shall provide notice of COBRA Continuation Coverage election that shall inform such individual of his or her rights and obligations with respect to COBRA Continuation Coverage under the Plan.

A Qualified Beneficiary who is an Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events:

- (a) termination of employment (other than for gross misconduct); or
- (b) reduction of hours of employment with the Employer.

COBRA Continuation Coverage for Dependent. Subject to Section 10.5, a Qualified Beneficiary who is a Dependent may elect COBRA Continuation Coverage, at his own expense, if:

- (a) his participation under the Plan would terminate as a result of a Qualifying Event; or
- (b) the Dependent is a child born to, adopted by or placed for adoption with a Qualified Beneficiary during the period of COBRA Continuation Coverage.

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of sixty (60) days from the later of:

- (a) loss of coverage;
- (b) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage; or
- (c) the date coverage would otherwise cease.

Special enrollment rights under HIPAA, as described in Section 11.10, may be available to Qualified Beneficiaries receiving COBRA Continuation Coverage. In such case, enrollment must be completed within the minimum enrollment period afforded by law relative to the event giving rise to the special enrollment right or such longer time as may be permitted under a Welfare Program.

The Employer shall, in the event of a Qualifying Event that is either a Termination of Employment (other than for gross misconduct), a reduction of hours, death of the Employee, commencement of a proceeding in bankruptcy (as applicable) or the Employee becoming entitled to Medicare benefits (as applicable), notify the Plan Administrator (or its designee) within thirty (30) days of the later of the date of the Qualifying Event or the date that coverage under the Plan ends. Such notice shall be given in a form and manner as determined by the Plan Administrator, in its sole discretion, in compliance with applicable law. The Plan Administrator shall then notify the Covered Employee and all covered Dependents of their right to elect COBRA Continuation Coverage within fourteen (14) days of such notice from the Employer.

Failure to enroll for COBRA Continuation Coverage during the established enrollment period will terminate all rights to COBRA Continuation Coverage under this Article X and such right to COBRA Continuation Coverage shall not be reinstated, unless otherwise required by law. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by an Employee or his Spouse shall be deemed to be an election for that Employee's Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

In the event the Plan Administrator determines that an Employee, Dependent or Qualified Beneficiary who has furnished a notice of a Qualifying Event, second Qualifying Event or disability determination is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide a notice of unavailability of COBRA Continuation Coverage to such affected individual in accordance with 29 CFR Part 2590.606-4(c).

### **Section 10.3 Period of COBRA Coverage.**

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of the Employee's Termination of Employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months measured

from the date of the Qualifying Event. With respect to all other Qualifying Events, a Qualified Beneficiary (other than the Employee) may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

A Qualified Beneficiary who properly elects and renders payment for the initial Continuation Coverage Contribution shall have such COBRA Continuation Coverage effective on the date of the Qualifying Event.

Coverage under this Section 10.3 may not continue beyond:

- (a) the date on which the Employer ceases to maintain a group health plan;
- (b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 10.4 of this Plan;
- (c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;
- (d) the date a Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes covered under another group health plan;
- (e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members who are also Qualified Beneficiaries) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 10.6 herein, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be “disabled” within the meaning of the Social Security Act; or
- (f) the maximum COBRA Continuation Period required by law.

COBRA Continuation Coverage may also terminate for any reason the Plan would terminate coverage for any enrolled individual not receiving COBRA Continuation Coverage (such as fraud on the Plan).

In the event the Plan Administrator terminates COBRA Continuation Coverage of a Qualified Beneficiary prior to the end of the maximum available Continuation Coverage Period, the Plan Administrator shall provide a notice of such termination to each affected Qualified Beneficiary in accordance with 29 CFR 2590-606-4(d).

#### **Section 10.4 Contribution Requirements for Coverage.**

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of the initial election of COBRA Continuation Coverage to pay the Continuation

Coverage Contributions for the first month, plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or be retroactively cancelled.

The Qualified Beneficiary shall have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. Once terminated, COBRA Continuation Coverage shall not be reinstated.

Except as provided in Section 10.6 or otherwise under applicable law or a Welfare Program, the Continuation Coverage Contribution shall be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section 10.4, an amount is "not significantly less" than the Continuation Coverage Contribution if it varies by no more than the lesser of fifty dollars (\$50) or ten percent (10%) of the required Continuation Coverage Contribution amount.

**Section 10.5 Limitation on Qualified Beneficiary's Rights to COBRA Continuation Coverage.**

If a Qualified Beneficiary loses, or will lose health coverage under the Plan as a result of divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Employee must notify the Plan Administrator within a maximum of sixty (60) days of the divorce, legal separation or loss of Dependent status. Such notice shall be required to comply with the Plan's notice procedures as contemplated by Section 10.11 of this Plan, in accordance with applicable law. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article X; such right shall not be reinstated.

A Qualified Beneficiary must notify the Plan Administrator of the birth to, adoption or placement for adoption of a child while receiving COBRA Continuation Coverage. The notice must be provided within the minimum period afforded by law or such longer time as may be permitted under a Welfare Program, subject to the Plan's notice procedures as contemplated by Section 10.11 of this Plan.

**Section 10.6 Extension of COBRA Continuation Coverage Period.**

If a second Qualifying Event that is not a Termination of Employment or reduction in hours occurs during an eighteen (18) month COBRA period explained in Section 10.3, COBRA Continuation Coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualified Beneficiaries. A second Qualifying Event will result in an extension of the initial Continuation Coverage Period only if such Qualifying Event would have resulted in a loss of coverage under the Plan had the first Qualifying Event not occurred. Such extension of COBRA Continuation Coverage can apply only to Qualified Beneficiaries other than the Employee. Such extension could apply to a child adopted by or placed for adoption with a Qualified Beneficiary during the COBRA period, but would not apply to a Spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period. Notwithstanding the foregoing, terminating employment after a Qualifying Event that is a reduction in hours of employment does not extend the maximum Continuation Coverage Period beyond eighteen (18) months of COBRA Continuation Coverage for any Qualified Beneficiary.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

- (a) The Social Security Administration determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or anytime within the first sixty (60) days of COBRA Continuation Coverage and such disability lasts at least until the end of the initial eighteen (18) month COBRA period, and
- (b) The disabled Qualified Beneficiary provides evidence to the Plan Administrator of such Social Security Administration determination within sixty (60) days of the date of such determination but not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage in a manner consistent with the Plan's reasonable notice procedures as contemplated by Section 10.11 of this Plan. Failure to notify the Plan Administrator of such determination within the time period stated above will result in the loss of the right to an extension of the initial eighteen (18) month period of COBRA Continuation Coverage and such right will not be reinstated.

In the event of a disability extension, the Continuation Coverage Contribution shall be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19<sup>th</sup>) through twenty-ninth (29<sup>th</sup>) month of COBRA Continuation Coverage. However, the Continuation Coverage Contribution shall continue to be one hundred two percent (102%) of the cost of coverage for Qualified Beneficiaries who are entitled to a disability extension, but who also experience a second Qualifying Event during the first eighteen (18) months of COBRA coverage.

If a Qualified Beneficiary who meets the above requirements receives a final determination from the Social Security Administration that he or she is no longer disabled, the Qualified Beneficiary

must notify the Plan Administrator within thirty (30) days of the date of that determination in a manner consistent with the Plan's notice procedures in Section 10.11 of this Plan. Such a final determination shall end the disability extension of COBRA coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date or (ii) the end of the Continuation Coverage Period without regard to the disability extension.

**Section 10.7 Responses to Information Regarding Qualified Beneficiary's Right to Coverage.**

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan Administrator to confirm coverage of a Qualified Beneficiary during the COBRA Continuation Coverage election period, the Plan Administrator will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA Continuation Coverage is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan Administrator to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan Administrator will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

**Section 10.8 Coordination of Benefits - Medicare and COBRA.**

For purposes of this Article X, "Medicare Entitlement" means being entitled to Medicare due to either: (1) enrollment (automatically or otherwise) in Medicare Parts A or B, or (2) being medically determined to have end-stage renal disease ("ESRD"), and (a) having applied for Medicare Part A; (b) having satisfied any waiting period requirement and (c) being either (i) insured under Social Security, (ii) entitled to retirement benefits under Social Security or (iii) a spouse or dependent of a person satisfying either (i) or (ii).

If an Employee has a Qualifying Event due to his Termination of Employment or reduction in work hours, and such Qualifying Event occurs less than eighteen (18) months after the date the Employee became entitled to Medicare, the maximum period of COBRA Continuation Coverage for the Employee's Dependents shall be extended to the last day of the thirty-six (36) month period measured from the date the Employees became entitled to Medicare, while the maximum period of COBRA Continuation Coverage for the Employee is eighteen (18) months from the Qualifying Event, subject to the termination of coverage provisions of the applicable group health Welfare Program.

If an Employee has a Qualifying Event due to his Termination of Employment or reduction in work hours and, after the Employee has elected COBRA Continuation Coverage and during the first eighteen (18) months of COBRA Continuation Coverage, the Employee first becomes entitled to Medicare, the Employee's COBRA Continuation Coverage shall end. COBRA Continuation Coverage with respect to the Employee's Dependents who are Qualified Beneficiaries and who have elected COBRA Continuation Coverage shall not be terminated due to the Employee's entitlement to Medicare and shall continue through the remainder of the maximum eighteen (18) month Continuation Coverage Period, subject to the termination of the coverage provisions set forth herein and in the applicable group health Welfare Program.

**Section 10.9 Relocation and COBRA Coverage.**

If a Qualified Beneficiary moves outside the service area of a region-specific group health benefit package, alternative coverage, if available to similarly situated active Employees, will be made available to the Qualified Beneficiary no sooner than (i) the date of the Qualified Beneficiary's relocation; or if later, (ii) the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

**Section 10.10 COBRA Coverage and HIPAA Special Enrollment Rules.**

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") rules as if the Qualified Beneficiary were an Employee in the Plan, provided that such family members may not become Qualified Beneficiaries, pursuant to Section 10.2, and may not be eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between this Plan and any future coverage under another group health plan, may preserve the Qualified Beneficiary's creditable coverage period and reduce or avoid applicable pre-existing condition exclusions under another group health plan.

**Section 10.11 Procedures for Providing Notices.**

The Plan Administrator shall establish procedures for the furnishing of notices required by an Employee, Dependent or Qualified Beneficiary to the Employer and/or Plan Administrator including Qualifying Event notices, notice of disability determination or Medicare entitlement, change in disability determination, and Medicare entitlement. Such procedures will: (i) be described in this Plan and/or each Welfare Program's Summary Plan Description; (ii) specify the individual or entity designated to receive such notices; (iii) specify the form and means of delivery of such notices (including requiring the use of certain forms when submitting such notices); (iv) describe the information required by the Plan to provide COBRA Continuation Coverage rights; and (v) shall comply with applicable Federal laws regarding requirements for timing and content of such notices.

**Section 10.12 Definitions.**

For purposes of this Article X only, the following definitions shall apply:

- (a) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- (b) **"COBRA Continuation Coverage"** means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage shall be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of this Plan are modified for Similarly Situated Beneficiaries, such coverage shall also be modified in the same manner for all Qualified Beneficiaries as of

the same date. Open enrollment rights extended to active Employees will also be extended to Similarly Situated Qualified Beneficiaries.

- (c) **“Continuation Coverage Contribution”** means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for COBRA Continuation Coverage.
- (d) **“Continuation Coverage Period”** means the applicable time period for which COBRA Continuation Coverage may be elected.
- (e) **“Dependent”** means:
  - i. a Spouse or other Dependent covered under this Plan on the day prior to the Qualifying Event; or
  - ii. a child who is born to, adopted by or placed for adoption with an Employee during the period of COBRA Continuation Coverage.
- (f) **“Employee”** means an Employee covered under this Plan on the day prior to the Qualifying Event. If an individual who otherwise would be an Employee for purposes of this Article is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered an Employee. To the extent required by law, Employee shall also include Former Employees of the Employer and their Dependents who meet the criteria to be a Qualified Beneficiary as a matter of law and/or the applicable Welfare Program.
- (g) **“Open Enrollment Period”** means a period during which an Employee covered under the Plan can choose to be covered under another Plan or under another benefit option within the same plan, or add or eliminate coverage of family members.
- (h) **“Qualified Beneficiary”** means an Employee or Dependent meeting the criteria established by law and set out in this Plan (and/or an applicable Welfare Program).
- (i) **“Qualifying Event”** means any of the following events which would otherwise result in an Employee’s or Dependent’s loss of health coverage in the absence of this provision:
  - i. an Employee’s Termination of Employment, for any reason other than gross misconduct;
  - ii. an Employee’s reduction in work hours resulting in a change of employment status such that the Employee is no longer eligible to participate in a group health Welfare Program;
  - iii. an Employee’s divorce or legal separation;
  - iv. a Dependent ceasing to qualify as a Dependent under the provisions of this Plan;

- v. an Employee's entitlement to benefits under Medicare (but only if group health benefit coverage under this Plan would otherwise terminate upon Medicare entitlement as permitted by applicable law);
- vi. the death of an Employee; or
- vii. the failure of an Employee to return from FMLA leave.

Loss of coverage includes any increase in the premium or contribution that must be paid by the Employee (or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in subsections (i) – (vii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Former Employee covered under the Plan, that Former Employee (and his Dependents) may become a Qualified Beneficiary with respect to the bankruptcy.

- (j) **“Similarly Situated Beneficiaries”** means Employees or their Dependents, as applicable, who are enrolled in this Plan.

**ARTICLE XI  
MISCELLANEOUS FEDERAL LAW PROVISIONS**

**Section 11.1 Qualified Medical Child Support Orders.**

Rules relating to Qualified Medical Child Support Orders ("QMCSO") - Any health plan offered under this Plan shall provide benefits in accordance with the applicable requirements of any QMCSO.

Definitions – For purposes of Section 11.1, 11.2, 11.3 and 11.4, the following definitions apply:

- (a) The term "Qualified Medical Child Support Order" shall be defined for purposes of Sections 11.1, 11.2, 11.3 and 11.4 as follows: A Medical Child Support Order:
  - i. which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant, Dependent or Beneficiary is eligible under a group health plan; and
  - ii. with respect to which the requirements of Sections 11.1(a), 11.1(b) and 11.1(c) are met.
  
- (b) The term "Medical Child Support Order" shall be defined in these Sections 11.1, 11.2 and 11.3 as follows: Any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:
  - i. provides for child support with respect to a child of a Participant, Dependent or Beneficiary under a health plan offered under this Plan or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under the health plan offered under this Plan; or
  - ii. enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a health plan offered under this Plan.
  
- (c) For purposes of Sections 11.1, 11.2, 11.3 and 11.4, the term "Alternate Recipient" shall be defined as follows: Any child of a Participant, Dependent or Beneficiary who is recognized under a Medical Child Support Order as having the right to enrollment under a health plan provided within the Plan with respect to such individual.

Information to be Included in a QMCSO - A Medical Child Support Order meets the requirements of this Section only if such order clearly specifies:

- (a) the name and the last known mailing address (if any) of the Participant, Dependent or Beneficiary, as applicable, and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing

address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

- (b) a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined; and
- (c) the time period to which such order applies.

Restriction on New Types or Forms of Benefits - A Medical Child Support Order meets the requirements of this Section only if such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

QMCSO Coverage Ends - A child who is covered pursuant to a QMCSO shall have coverage end on the date the QMCSO expires or the date on which the child becomes ineligible under the terms of the Plan.

### **Section 11.2 Procedural Requirements.**

Timely Notifications and Determinations - In the case of any Medical Child Support Order received by the Plan Administrator for a health plan offered under this Plan –

- (a) the Plan Administrator shall promptly notify the Participant, Dependent or Beneficiary, as applicable, and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether a Medical Child Support Order is a QMCSO; and
- (b) within a reasonable period of time after receipt of such order, the Plan Administrator shall determine whether such order is a QMCSO and notify the Participant, Dependent or Beneficiary, as applicable, and each Alternate Recipient of such determination.

Establishment of Reasonable Procedures - The Plan Administrator shall establish reasonable procedures to determine whether a Medical Child Support Order is a QMCSO and to administer the provisions of benefits under such QMCSO. Such procedures:

- (a) shall be in writing;
- (b) shall provide for the notification of each person specified in a Medical Child Support Order who is named as eligible to receive benefits under the Plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the Plan Administrator of the QMCSO;
- (c) shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a QMCSO; and

- (d) Shall be available to Plan Participants, Dependents or Beneficiaries, as applicable, free of charge, upon request.

**Section 11.3 Actions Taken By Fiduciaries.**

General Requirement - If the Plan Administrator acts in accordance with Sections 11.1, 11.2, 11.3 and 11.4 in treating a Medical Child Support Order as being (or not being) a QMCSO, then the Plan's obligation to the Participant, Dependent or Beneficiary, as applicable, and each Alternate Recipient shall be discharged.

Treatment of Alternate Recipients:

- (a) An individual who is an Alternate Recipient under a QMCSO shall be considered a Beneficiary under the Plan for purposes of any provision of ERISA.
- (b) An individual who is an Alternate Recipient under any QMCSO shall be considered a Participant under the specific health plan for purposes of the reporting and disclosure requirements of Title I of ERISA.

Direct Provision of Benefits Provided to an Alternate Recipient - Any payment for reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

Payment to State Official Treated as Satisfaction of Plan's Obligation to Make Payment to Alternate Recipient - Payment of benefits by the Plan to an official of a state or a political subdivision thereof, whose name and address have been substituted for the name and address of an Alternate Recipient in a QMCSO, shall be treated as payment of benefits to the Alternate Recipient.

**Section 11.4 National Medical Support Notice Deemed to be a Qualified Medical Child Support Order.**

- (a) An appropriately completed National Medical Support Notice ("Notice") promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 shall be deemed to be a QMCSO if the Notice does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under this Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993), and the Notice clearly specifies the following:
  - i. the name and the last known mailing address (if any) of the Participant, Dependent or Beneficiary, as applicable, and the name and mailing address of each Alternate Recipient (an official of a state or political subdivision may be substituted for the mailing address of any Alternate Recipient, if provided for in the Notice);

- ii. a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
  - iii. the period to which the Notice applies.
- (b) If a Notice which satisfies Section 11.4(a) above, is issued for a child of a Participant, Dependent or Beneficiary under this Plan who is a non-custodial parent of the child, the Plan Administrator, within forty (40) business days after the date of the Notice, shall:
- i. notify the state agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of this Plan and, if so, whether such child is covered under this Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such child pursuant to Section 11.4(a)(1) above) to effectuate the coverage; and
  - ii. provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
- (c) Nothing in this Section 11.4 shall be construed as requiring this Plan, upon receipt of Notice, to provide benefits under this Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of this Plan as in effect immediately before the receipt of such Notice.

**Section 11.5 Rights of States with Respect to Group Health Plans Where Participants or Beneficiaries Thereunder are Eligible for Medicaid Benefits.**

- (a) Compliance by Plans with Assignment of Rights - A Welfare Program offered under this Plan that provides health benefits shall comply with any assignment of rights made by or on behalf of a Participant, a Dependent or a Beneficiary 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 the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) (Medicaid).
- (b) Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility - In determining or making any payments for benefits to an individual as a Participant, Dependent or Beneficiary, the fact that the individual is eligible for or such benefit is provided under Medicaid will not be taken into account.
- (c) Acquisition by States of Rights of Third Parties - If payment has been made under Medicaid for an item or service covered under this Plan, and this Plan has a legal obligation to make payment for such items or services under the law, payment for benefits under this Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant, Dependent or Beneficiary to such payment for such items or services; provided, however that in no event shall such a state law be applied to the extent it attempts to create rights for Medicaid which are greater than those of the

Participant, Dependent or Beneficiary under the Plan, specifically including any state law which provides that Medicaid can make a claim for benefits or recover benefits beyond the period permitted under the Plan.

**Section 11.6 Health Program Coverage of Dependent Children in Cases of Adoption.**

- (a) Coverage Effective Upon Placement For Adoption - In any case in which a Welfare Program offered under this Plan provides health coverage for a Child of a Participant, Spouse, Domestic Partner or Beneficiary, such Plan shall provide benefits to a Child Placed for Adoption with a Participant, Spouse, Domestic Partner or Beneficiary under the same terms and conditions as apply in case of a Child who is a natural Child of a Participant, Spouse, Domestic Partner or Beneficiary under the Plan, irrespective of whether the adoption has become final.
- (b) Restrictions Based on Preexisting Condition(s) at Time of Placement For Adoption are Prohibited - A health plan offered under this Plan may not restrict coverage under such Plan for any Child adopted by, or Placed For Adoption with, a Participant, Spouse, Domestic Partner or Beneficiary solely on the basis of a preexisting condition of such Child at the time that such Child would otherwise become eligible for coverage under the Plan.
- (c) Definitions - For purposes of this Section 11.6, the following definitions apply:
  - i. **"Child"** means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption, subject to applicable law prohibiting the application of preexisting condition limitations to children under age nineteen (19).
  - ii. **"Placement," "Placement For Adoption,"** or being **"Placed For Adoption"**, in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child or the Placement for Adoption in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

**Section 11.7 Continued Coverage of Costs of a Pediatric Vaccine Under Group Health Plans.**

A health plan offered under this Plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section 1928(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

**Section 11.8 Family and Medical Leave Act.**

The Plan will comply with the Federal Family and Medical Leave Act ("FMLA") with regard to health coverage while on family and medical leave and reenrollment rights upon return from family and medical leave to the extent required under Federal law, and if applicable, state law. If an Employee takes a leave pursuant to the FMLA, health coverage for such Employee (and any Dependents) may continue, subject to the Employee's continued participation in the Plan while on

FMLA leave, on the same basis as for active Employees for the first day on which such approved leave began until the end of the FMLA leave, pursuant to the requirements of the FMLA.

- (a) Re-enrollment. An Employee whose coverage terminates during a leave granted pursuant to the FMLA because of failure to make any contribution, if required, shall be eligible to re-enroll in the Plan immediately upon timely return from the FMLA leave. In the event the Employee fails to render the required premium contribution for continuation of Welfare Program coverage while on FMLA leave within the timeframe established by the Plan or otherwise established by law, the Plan Administrator may notify the Employee of such termination at least fifteen (15) days before the termination of such coverage. Coverage shall commence on the day of his or her return to employment or active service subject to uniform policies for election of coverage established by the Plan Administrator.
- (b) COBRA. An approved leave of absence, which may include a leave pursuant to the FMLA, does not constitute a Qualifying Event under COBRA. Failure to timely return from FMLA leave may result in a Termination of Employment that may trigger a COBRA Qualifying Event. In such circumstance, the last day of the Employee's FMLA leave shall be deemed the date the Qualifying Event occurred. Notification of an Employee's intent not to return from FMLA leave will result in a Termination of Employment that will trigger a COBRA Qualifying Event. In this circumstance, the date of the Employee's notification of intent not to return from FMLA leave shall be deemed the date the Qualifying Event occurred.
- (c) Contributions. An Employee in the Plan who takes FMLA leave is entitled to continue to participate in the health coverage provided under this Plan during such FMLA leave. However, the Employee may revoke his election to participate in the Company's Section 125 plan while on Employer-approved FMLA leave. If the Employee does not revoke his Section 125 plan election, the Employee must continue to pay for his or her portion of the premium for such Welfare Program coverage. The Participant must either: (i) pre-pay his or her portion of the required contributions for the entire leave period (ii) continue to make contributions to the Plan on a pay-as-you-go basis, or (iii) upon previous arrangement and agreement with the Plan Administrator, pay his or her portion of required contributions with subsequent premium payments following the Employee's return from leave, as permitted under uniform policies adopted by the Plan Administrator. In the event that the Employer pays the Employee's portion of the premium contribution while the Employee is on FMLA leave and the Employee fails to timely return from such leave or fails to repay the Employer for such contributions upon return from FMLA leave, the Employer may, in its sole discretion and in accordance with uniform policies, collect such premiums from the Employee in a time and manner permitted by law. If the Employee revokes his election to participate in the Company's Section 125 plan, then the Employee may, upon timely return from FMLA leave, elect to reinstate his election to participate in the Section 125 plan, subject to the uniform policies regarding change in elections as established under the Employer's Section 125 plan.
- (d) Reinstatement. If an Employee's benefits have terminated while on FMLA leave, such benefits will be reinstated upon timely return from FMLA leave, subject to the uniform policies regarding change in elections established under the Company's Section 125 plan.

**Section 11.9 Uniformed Services Employment and Reemployment Rights Act.**

The Plan shall comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

- (a) An Employee who is not at work because of a period of duty in the Uniformed Services, may, at the Employee’s election, continue coverage in any or all Welfare Programs under the Plan during the period of absence, so long as the Participant satisfies the necessary provisions and makes any required notifications and contributions as provided under USERRA.
- (b) The maximum period of coverage for an Employee, Dependent or Beneficiary,, if any, under a Welfare Program during a period of duty in the Uniformed Services shall be governed by the applicable limitations and provisions contained in USERRA unless more generous limitations are provided under the Company’s leave of absence policy.
- (c) An Employee who elects to continue coverage in one or more Welfare Programs under this Plan shall pay:
  - i. the Employee’s share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or
  - ii. no more than one hundred-two percent (102%) of the full premium or cost of coverage under the Plan (determined in the same manner as the applicable COBRA Continuation Coverage premium under Section 4980B(f)(4) of the Code) if the Employee performs service in the Uniformed Services for thirty-one (31) days or more.
- (d) During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under this Plan, if any, by:
  - i. remitting payment to the Employer on or before each pay period for which the contributions would have been deducted from the Employee’s paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days of their due date;
  - ii. at the Employee’s request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee’s paychecks preceding such period of service in the Uniformed Services; or
  - iii. pre-approved arrangement with the Plan Administrator and in accordance with uniform policies adopted by the Plan Administrator wherein the Employer pays the Employee’s contributions during the Employee’s period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, shall be eligible to return to work and immediately participate in the same Welfare Programs which the Employee had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Welfare Programs that affect the workforce as a whole, provided that the Employee returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Employee makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in uniform policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to an Employee (and his Dependents) while on a USERRA leave of absence shall end on the earlier of: (i) the last day of the twenty four (24) month period beginning on the date on which the Employee's absence begins (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Welfare Program coverage to continue) or (ii) the day after the date upon which the Employee fails to timely apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Employee pays the full amount which the Employer has, in its discretion charged the Employee for health coverage under USERRA), an Employee who experiences a reduction in hours or termination of employment solely due to a USERRA leave shall continue to be considered qualified as an Employee under the Plan until the earliest date that the termination of his health benefits is permitted under USERRA.

- (e) For the purposes of this Section 11.09, the following definition applies:
  - i. **“Uniformed Services”** means the 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 persons designated by the President of the United States of America in time of war or emergency.

**Section 11.10 Health Insurance Portability and Accountability Act.**

The Plan shall comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) with respect to a Welfare Program offered under the Plan that provides health benefits. This Section 11.10 shall not apply to a Welfare Program which does not provide health benefits subject to HIPAA.

- (a) Eligibility - The Plan shall not base eligibility rules or waiting periods on any of the following: health status, mental or physical medical condition, genetic information or evidence of insurability or disability, or claims experience. However, the Plan may continue to provide for the exclusion of specified health conditions or lifetime maximums, subject to applicable law, on either specific benefits or all benefits provided under the Plan. These restrictions do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

- (b) Enrollment - Special enrollment periods shall generally be provided for Employees and Dependents who decline enrollment in the Plan because of other group health coverage and subsequently lose such other coverage. Such individuals may enroll in the Plan if the Employee requests enrollment within thirty-one (31) days of the loss. The loss of other group health coverage must be from either: (i) exhaustion of the maximum period of COBRA Continuation Coverage or (ii) loss of non-COBRA coverage under another plan that is a result of (a) termination of coverage or (b) employer contributions for coverage were terminated. Voluntary loss of other coverage under another group health plan does not qualify as a loss of coverage that entitles an Employee or Dependent to a special enrollment right under this Plan.

Special enrollment periods shall also be available for the acquisition of new Dependents of a Participant (and certain Dependents, as required by law and as otherwise provided under the terms of a specific Welfare Program) as a result of marriage, birth, adoption or placement for adoption (and possibly other events if permitted by a specific Welfare Program), if enrollment is requested within a period of thirty-one (31) days following the applicable event. In the event of an acquisition of a new Dependent due to birth, adoption or placement for adoption (and possibly other events if permitted by a specific Welfare Program), coverage may be effective retroactively to the date of such birth, adoption or placement for adoption. All other enrollment pursuant to a HIPAA special enrollment right shall be effective no later than the first day of the month following the date the Plan Administrator receives the completed enrollment form.

Notwithstanding any other provision of the Plan, if a Participant (or certain Dependents, as required by law and as otherwise provided under the terms of a specific Welfare Program) loses eligibility for coverage under Medicaid or a state children's health insurance program (CHIP), the Participant may be able to enroll himself (and certain Dependents, as required by law and as otherwise provided under the terms of a specific Welfare Program) in the Plan. Enrollment must be requested within sixty (60) days after coverage ends under Medicaid or CHIP. Further, if a Participant (or certain Dependents, as required by law and as otherwise provided under the terms of a specific Welfare Program) becomes eligible for premium assistance from Medicaid or CHIP for coverage under the Plan, the Participant may be able to enroll himself (and certain Dependents, as required by law and as otherwise provided under the terms of a specific Welfare Program) in the Plan. Enrollment must be requested within sixty (60) days after the determination of eligibility for such premium assistance.

- (c) HIPAA and COBRA Continuation Coverage - COBRA Continuation Coverage, as amended by HIPAA, shall be provided in accordance with Article X herein. HIPAA special enrollment rights may be available to Qualified Beneficiaries receiving COBRA Continuation Coverage under the Plan.
- (d) Administrative Simplification (Privacy) – The Plan will comply with the privacy regulations under HIPAA, as amended from time to time, and shall be construed solely

for that purpose. For purposes of this Section 11.10(e), the term “Protected Health Information” shall have the meaning set forth in the privacy regulations under HIPAA.

- i. The Plan may use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the privacy regulations thereunder. Without limiting the foregoing, the Plan may use and disclose Protected Health Information for “Payment”, “Treatment”, and “Health Care Operations” purposes as such terms are defined by the HIPAA privacy regulations.
  - (A) “Payment” includes activities undertaken by the Plan to obtain premiums or determine or fulfill the Plan’s responsibility for coverage and provision of benefits under the terms of the Plan or to provide reimbursement for the provisions of health care, including without limitation, determining eligibility; conducting pre-certification, utilization and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints and appeals.
  - (B) “Treatment” includes, but is not limited to, the provision, coordination, or management of health care and related services by one or more health care providers. For example, doctors may request medical information from the Plan to supplement their own records.
  - (C) “Health Care Operations” include, but are not limited to, conducting quality assessment and improvement activities, case management and care coordination, contacting health care providers and individuals with information about treatment alternatives, related functions that do not include treatment, reviewing and evaluating qualifications and/or Plan performance, securing contracts for reinsurance, conducting or arranging for medical review or auditing functions (including fraud and abuse detection), and business planning and development (including methods of payment or coverage policies). The Plan is prohibited from using or disclosing Protected Health Information that is genetic information for underwriting purposes.
- ii. Protected Health Information may be disclosed by the Plan to the Employer and the Employer may use and disclose Protected Health Information for Plan administration purposes, for enrollment purposes, and for any other purposes consistent with an individual’s authorization or permitted by the HIPAA privacy regulations. In addition, “summary health information” may be disclosed by the Plan to the Employer and may be used and disclosed by the Employer for purposes of obtaining premium bids for health information coverage under the Plan or modifying, amending, or terminating the Plan.

- iii. Prior to receiving Protected Health Information from the Plan, the Employer agrees that it will:
- (A) Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as permitted or required by law;
  - (B) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (C) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other non-health benefit or employee benefit plan of the Employer (unless authorized by the individual or permitted by the HIPAA privacy regulations);
  - (D) Report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for and of which it becomes aware;
  - (E) Make available Protected Health Information to the affected individual in accordance with Section 164.524 of the HIPAA privacy regulations;
  - (F) Make available Protected Health Information for amendment at the request of the affected individual and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the HIPAA privacy regulations;
  - (G) Make available the information required to provide an accounting of disclosures to an affected individual in accordance with Section 164.528 of the HIPAA privacy regulations;
  - (H) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the applicable requirements of the HIPAA privacy regulations;
  - (I) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the 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

- (J) Ensure that the adequate separation described in Section 11.10(e)(iv) is established.
- iv. With respect to Protected Health Information disclosed by the Plan to the Employer for use and/or disclosure by the Employer for Plan administration purposes:
- (A) Such information may be disclosed to employees in the Fluor Corporation Benefits Department or other departments designated from time to time with oversight responsibility for the Plan, including employees with oversight responsibility for claims payment and third party claims administration;
  - (B) Such information may be used by the persons described above only for purposes of the Plan administration functions that the Employer performs for the Plan; and
  - (C) Compliance with the provisions above relating to disclosure for Plan administration purposes shall be monitored and enforced by the Plan Administrator. The Plan Administrator shall establish rules for effectively resolving any instances of noncompliance. Such rules are incorporated herein by this reference.
- (e) Administrative Simplification (Security) – The Plan will comply with the security regulations under HIPAA, as amended from time to time, and shall be construed solely for that purpose. For purposes of this Section 11.10(f), the term “Electronic Protected Health Information” shall have the meaning set forth in the Security regulations under HIPAA.
- i. The Employer agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan.
  - ii. Ensure that adequate separation between the Plan and Employer is supported by reasonable and appropriate security measures.
  - iii. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and
  - iv. Report to the Plan any security incident of which the Employer becomes aware.

**IN WITNESS WHEREOF**, the Company has caused this Plan to be amended and restated effective as of October 1, 2015, except as otherwise stated herein.

**FLUOR FEDERAL SERVICES, INC.**

By: Robert M. Nichols

Title: VP, Fluor Federal Services .

**FLUOR FEDERAL SERVICES, INC. PADUCAH DEACTIVATION PROJECT  
HEALTH & WELFARE PLAN**

**APPENDIX A**

Effective October 1, 2015, the following Welfare Programs shall be treated as comprising the Fluor Federal Services, Inc. Paducah Deactivation Project Health & Welfare Plan pursuant to Section 1.2 herein:

Benefit	Full-Time Active Non-Grandfathered FPDP Employees	Full-Time Active Grandfathered FPDP Employees
1. Medical and Prescription Drug	Eligible on date of hire	Eligible for benefits under the ETTP MEWA in accordance with its terms
2. Dental	Eligible on date of hire	Eligible for benefits under the ETTP MEWA in accordance with its terms
3. Vision	Eligible on date of hire	Eligible for benefits under the ETTP MEWA in accordance with its terms
4. Life Insurance / AD&D	Eligible on date of hire	Eligible for benefits under the ETTP MEWA in accordance with its terms
5. Short Term Disability	1 <sup>st</sup> of the month following date of hire	1 <sup>st</sup> of the month following date of hire
6. Long Term Disability	1 <sup>st</sup> of the month following date of hire	Eligible for benefits under the ETTP MEWA in accordance with its terms
7. Business Travel	Eligible on date of hire	Eligible on date of hire
8. Flexible Spending Accounts Three options: Medical FSA (\$2,500 limit) Dependent Care FSA (\$5,000 limit)	Eligible on date of hire	Eligible on date of hire
9. EAP	Eligible on date of hire	Eligible on date of hire
10. Severance	One week per year of service up to two (maximum of two weeks)	Eligible for benefits under the ETTP MEWA in accordance with its terms

For purposes of this Appendix A:

Grandfathered Employees.

A “Grandfathered” Employee is an Employee who is eligible for the Eastern Tennessee Technology Park Health and Welfare Benefit Plan, a multiple employer plan (the “ETTP MEWA”). “Grandfathered Employee” eligible for the ETTP MEWA means an individual who meets **both** Condition A and Condition B.

**Condition A: The individual was either:**

- (1) an employee of Lockheed Martin Energy Systems, Lockheed Martin Utility Services or Lockheed Martin Energy Research (collectively, "LM") on **March 31, 1998**; or
- (2) a bargaining unit member of the Paper, Allied-Industrial, Chemical and Energy Workers International Union, AFL-CIO (PACE/USW) (at ETTP) who was on the LM recall list on **March 31, 1998**; or
- (3) a **bargaining unit member** of the Atomic Trades and Labor Council (ATLC) (at the Oak Ridge National Lab or Y-12 Plant) or PACE (USW) (at the Portsmouth Gaseous Diffusion Plant or Paducah Gaseous Diffusion Plant) who was either: (i) an LM employee; (ii) a USEC employee; or (iii) on the LM or USEC recall list on the date of the applicable bargaining unit transition agreement ("BUTA") - If yes to 3(iii) above on recall list under BUTA, the Employee must provide documentation of recall list date and dates for applicable BUTA.

**Condition B: The individual was either:**

- (1) subsequently employed by the Contractor (Bechtel Jacobs) or its first-tier or second-tier subcontractors for work in Covered Employment prior to **April 1, 2000**; or
- (2) a USEC Employee (at the Portsmouth Gaseous Diffusion Plant or Paducah Gaseous Diffusion Plant) who transitions directly to the Contractor (Fluor Federal Services Paducah Deactivation Project (FPDP)) or its first-tier or second-tier subcontractors for work in Covered Employment after **March 31, 2000**, and before **January 1, 2001**; or
- (3) a former USEC employee (at Portsmouth Gaseous Diffusion Plant or Paducah Gaseous Diffusion Plant) who received an **involuntary reduction-in-force after March 31, 2000 and**, is subsequently hired by the Contractor (FPDP) or its first-tier or second-tier subcontractors for work in Covered Employment **before January 1, 2001**; or
- (4) an employee covered by an **applicable bargaining unit transition agreement (BUTA – Only BUTA is TPMC USW CBA as transitioned and approved as such)** for which no employment deadline is specified.

An Employee who is not a Grandfathered Employee is a Non-Grandfathered Employee.

Full-time Employees. A "Full-time" Employee is an Employee who has an average of at least 30 hours of service per week in a month.

Fluor Federal Services, Inc. Paducah Deactivation Project ("FPDP") Employees. A FPDP Employee is an Employee hired by the Company on or after October 21, 2014 to work exclusively on the FPDP (Task Order No. DE-DT0007774 under Contract No. DE-EM0001131). No other Employees of the Company (or any affiliated Employer) are eligible for benefits under this Plan. FPDP Employees are not eligible for benefits under any other plans sponsored by the Company, an affiliated Employer, or URS/CH2M Oak Ridge LLC (UCOR).

Active Employees. An "Active" Employee is an Employee who is currently employed by the Company.

Collectively Bargained Employees. If an Employee is subject to a collective bargaining agreement and the collective bargaining agreement specifies different terms for eligibility than the terms described under this Appendix A, the rules in the collective bargaining agreement will control.

**FLUOR FEDERAL SERVICES, INC. PADUCAH DEACTIVATION PROJECT  
HEALTH & WELFARE PLAN**

**APPENDIX B**

Health and Welfare Program Documents