ASAHI KASEI HEALTH AND WELFARE PLAN

LEGAL WRAP PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Plan 501

Effective January 1, 2023

ADOPTION PAGE

PLAN NAME:	Asahi Kasei Health and Welfare Plan
PLAN NUMBER:	501
PLAN YEAR:	January 1 through December 31
PLAN EFFECTIVE DATE:	As amended and restated, January 1, 2023
PLAN SPONSOR, NAMED FIDUCIARY: PLAN ADMINISTRATOR AND AGENT	Asahi Kasei America, Inc. 13800 South Lakes Drive Charlotte, NC 28273 (704) 587-8882
EMPLOYER IDENTIFICATION NUMBER:	13-2698638

Asahi Kasei America, Inc. ("the Employer") has established for Eligible Employees a plan of health and welfare benefits, which may include medical, prescription drug, dental, vision, employee assistance program, basic and voluntary life and AD&D insurance, short-term and long-term disability insurance benefits, business travel and accident insurance benefits, and includes a Code section 125 - cafeteria plan benefits (including pre-tax premium payments, a health care spending account, a dependent care spending account, pre-tax employee contributions and discretionary employer contributions to health savings accounts, and an opt-out cash option in lieu of coverage).

This document, Asahi Kasei Health and Welfare Plan – Legal Wrap Plan Document and Summary Plan Description (the "Plan"), together with the Supplemental Plan Documents (as defined in Section 18) are intended to serve as the legal and formal wrap welfare benefit plan and summary plan descriptions.

The Plan Sponsor at any time for any reason may amend, change or terminate (in whole or in part) the Plan without the consent of any Eligible Employee or any other persons entitled to receive payment of benefits under the Plan.

IN WITNESS WHEREOF, this Plan has been adopted by the Employer on this 20th day of December, 2022, effective January 1, 2023.

ASAHI KASEI AMERICA, INC.

By: Shinji Ohno
Its: President

TABLE OF CONTENTS

Page

APPENDICES A-G

1. INTRODUCTION

Asahi Kasei America, Inc. (the "Employer") has established various welfare and fringe benefit plans for Eligible Employees of the Participating Employers listed in Appendix A. This Legal Wrap Plan Document and Summary Plan Description (referred to as "this Plan document") is intended to supplement the provisions of the welfare and fringe benefit arrangements to comply with various disclosure requirements mandated by law, clarify administrative procedures for and establish eligibility conditions under the benefit programs and join the welfare benefit programs together into one legal wrap plan document for annual reporting purposes (in the aggregate referred to as the "Plan"). The Plan is a single employer welfare benefits plan within the meaning of ERISA Section 3(1).

Except as otherwise set forth in the Plan document, a specific description of covered benefits as well as a description of the terms and conditions to receive such benefits are contained in separate plan documents, including the insurance certificates, contracts, booklets and formal plan documents (in the aggregate referred to as "Supplemental Plan Document"), all of which are incorporated by reference into this Plan document and together these documents constitute the legal plan document and summary plan descriptions for such welfare and fringe benefit programs. Various Employee Groups may receive coverage under different welfare benefit programs, and, thus, the applicable Supplemental Plan Documents that apply to each Employee Group may differ. To the extent not specifically set forth in this Plan document, the Supplemental Plan Documents may contain additional eligibility conditions to participate, and will contain a specific explanation of covered and excluded benefits (e.g. schedules of benefits), cost-sharing requirements, network requirements, other terms and conditions for receipt of benefits and the name and contact information for the Claims Administrator.

You should not rely on any oral explanations, description, or interpretation of the Plan by any employee or other person because the written terms of the Plan (including this Plan document and the applicable Supplemental Plan Documents (unless noted otherwise herein) always will govern. To the extent that there are any differences or inconsistencies in any employee communications, including but not limited to employee bulletins, employee web sites, etc., the inconsistency or differences will be controlled and determined by the terms of this Plan document and the Supplemental Plan Documents.

The Plan Administrator will furnish to you a copy of this Plan document as well as the summary portions of the applicable Supplemental Plan Document when you first become a Plan participant. You may obtain another copy of such documents at any time by contacting the Plan Administrator.

You also may examine all of the documents that make up the applicable Supplemental Plan Documents in the Plan Administrator's office, and may request a copy of such documents, but may be asked to pay for copying costs in some circumstances. If you have any questions about this Plan document or the Supplemental Plan Documents, or about the benefit programs described hereunder, you should contact the Plan Administrator.

The Employer expressly reserves the right to amend or revise any term or provision of the Plan or to terminate the Plan at any time in its sole discretion.

This Plan document reflects the terms of the Plan effective as of January 1, 2020. Please contact the Plan Administrator if you have questions regarding health and welfare benefit plans in effect prior to January 1, 2020. Please read these documents carefully and keep them with your personal records for future reference. You will be notified if any substantial changes are made after this date.

2. IMPORTANT FACTS ABOUT THE PLAN

2.1 Type of Plan, Type of Plan Administration and Source of Contributions.

The benefit programs offered under this Plan consist of the health, welfare and fringe benefit programs specified in Appendix B, each of which is an employee welfare benefit plan subject to and governed by ERISA, except for the Cafeteria Plan and the Dependent Care FSA Plan, which are included in the Plan document for ease of administration. The type of plan administration and the source of contributions for each of these benefit programs offered under this Plan document are described in Appendix B and the Supplemental Plan Documents.

Various Employee Groups (e.g. Full-Time or Part-Time Eligible Employees or other Employee Groups based on locations) may receive coverage, may be ineligible for or only have certain benefit options available to them under or have different cost-sharing requirements for the health, welfare and fringe benefits described in this Plan document. As a result, your Supplemental Plan Document may differ from other Employee Groups. The Plan Administrator will provide you with a copy of the Supplemental Plan Document that pertains to your Employee Group, which Supplemental Plan Document, along with the Appendix B will describe the choices available to your Employee Group for the Plan Year.

2.2 Sources of Funding.

All of the benefits and other amounts payable under this Plan shall be paid from either the general assets of the Employer or by an insurance provider. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid.

2.2.1 Self-Funded Benefits. A benefit that is self-funded means that the benefits are paid from the Employer's general assets and not fully-insured through an insurance company. The Employer, however, may engage a Claims Administrator to administer such self-funded benefit programs, including delegating to the Claims Administrator the discretionary authority to adjudicate claim and appeal decisions and to interpret the Supplemental Plan Documents and make factual determinations with respect to covered or excluded benefits.

For any self-funded benefits, if the Plan or the Employer does not ultimately pay covered expenses that are eligible for payment under this Plan document or the Supplemental Plan Document for any reason, the individuals covered by such benefit program may be liable for those expenses. The Claims Administrator merely processes claims and does not insure that any expenses of individuals covered under the self-funded benefit programs described under this Plan document will be paid. Complete and proper claims for self-funded benefits made by individuals covered under the terms of this Plan document will be promptly processed but that in the event there are delays in processing claims, the individuals covered by such benefit programs shall have no greater rights to interest or other remedies against the Claims Administrator than as otherwise afforded them by law.

2.2.2 Fully-Insured Benefits. During periods in which benefits under the Plan are fully insured, the insured benefits will be provided solely pursuant to the insurance contract (referred to as the Supplemental Plan Document in this Plan document) between the Employer and the Claims Administrator. If the terms of this Plan document conflicts with the terms of the Supplemental Plan Documents, the terms of the Supplemental Plan Documents will control, unless superseded by applicable law. For fully insured benefits, the Claims Administrator will be the claims fiduciary for purposes of deciding benefit claims with respect to the insured benefits, or if a denied claim is appealed, for deciding appeals both in accordance with its reasonable claims procedures as required by ERISA. The Claims Administrator, not the Employer, will be responsible for paying insured benefit claims. The Claims Administrator will be responsible for determining eligibility for and the amount of any insured benefits payable under the Plan; and providing the claims procedure to be followed and the claims forms to be used by Eligible Employees or their beneficiaries pursuant to the Supplemental Plan Document. The Claims Administrator also will have the authority to require that Eligible Employees furnish the Claims Administrator with such information as it determines is necessary for the proper administration of such Supplemental Plan Document.

2.3 Plan Fiduciary.

The Plan Fiduciary is the person or company that has the responsibility to control and manage the operation and administration of the Plan. The named Fiduciary and Plan Administrator for this Plan is the Employer. The Plan Administrator also has the authority to delegate and has delegated certain administrative responsibilities to the Employer's Benefits Department and certain Claims Administrators. No person or entity other than the Plan Fiduciary, or any person or entity to which the Plan Fiduciary has delegated any of its duties in writing, has the authority to interpret any provisions of the Plan. Any Employees who are involved in the administration of the Plan are acting on behalf of the Plan Fiduciary and not in their individual capacities.

2.4 Defined Terms.

Certain words and phrases used in this document have specific meanings that are defined in the text of the document or in Section 18, *Definitions*. Those words and phrases are capitalized.

3. CONTRIBUTIONS REQUIREMENTS

3.1 General Contribution Requirements for Eligible Employees.

The Employer and you share in the cost of your coverage under the Plan. You will make your contribution by paying a Premium Payment (which may include wellness and other surcharges), in addition to Copayments, Deductibles, and Co-insurance. When you enroll in coverage, you are authorizing the Employer to reduce your payroll by the share of your Premium Payment costs, in accordance with the procedures established under this Plan document and the Cafeteria Plan. The Cafeteria Plan allows you to pay your Premium Payments for certain benefit coverage on a pre-tax basis. The Plan Administrator will advise you in writing (electronic or otherwise) of the Premium Payment cost for coverage each Plan Year. Different Premium Payment costs may apply depending on the options you choose, the number of Eligible Family Members you cover, your Employee Group and if there are any wellness or other surcharges applied to you.

3.2 Premium Payments During Certain Absences.

To the extent permitted by law and this Plan document, if you are entitled to, elect to or are required to continue coverage under the Plan during certain periods of absence from work as set forth in Section 6.2, *Continuation of Coverage during Layoff or Certain Leave of Absence*, below (in the aggregate "Leave"), the additional rules set forth in this Section 3.2 apply to you regarding your Premium Payments during such Leave. Note, you may change your elections under this Plan during a Leave only as approved by the Plan Administrator in accordance the limited circumstances described under Sections 5 and 6 below.

3.2.1 Paid Leave. If you receive pay directly from the Employer during your Leave, Premium Payments automatically will be withheld from your continuing wages.

3.2.2 Unpaid Leave. If you receive no pay directly from the Employer during your Leave, you may elect to:

(A) Make payments to the Employer on a pre-payment basis from any taxable compensation paid to you. Any pre-payment made in one taxable year cannot be applied to a later taxable year.

(B) Make payments to the Employer on an after-tax basis at the same time as payment would be required if made by payroll deduction; or

(C) To the extent permitted by the Plan Administrator in its sole discretion, make payments to the Employer on a pre-tax or after-tax basis when you return from the leave; provided, however, that you and the Plan Administrator agree in advance of the leave that you elect to continue coverage while on an unpaid leave; the Employer will assume responsibility for advancing payment of your contributions during the leave; and the advance amounts must be paid by you when you return from the leave or when you fail to return to work after the leave period expires in accordance with a repayment schedule established by the Plan Administrator.

The Plan Administrator will provide more information regarding Premium Payments when your Leave begins.

3.2.3 Cessation of Coverage. If you fail to timely make any scheduled payments during your Leave, coverage under the Plan will cease retroactively to the date the required payment was due, provided, for a FMLA Leave, the Plan Administrator has given you at least 15 days advance written notice that if payment is not received within 30 days of the required due date, coverage will be dropped on that date retroactive to the date the required payment is due. If the notice is not timely sent during your FMLA Leave, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date.

3.2.4 Reinstatement. Subject to the rules set forth in Sections 5 and 6 below, if your coverage was suspended during a Leave and then return to work with the Employer within the same Plan Year the Leave commenced,

you automatically will resume participation in the Plan without any change in your prior elections for the remainder of such Plan Year (unless you experience another Qualified Status Change or Special Enrollment Event described in Section 5 below). Your Premium Payments will resume at the current rate for such coverage. You are not entitled to reimbursement for claims incurred during the period when your coverage was terminated or suspended under the Plan. If you return from a Leave in a Plan Year subsequent to the Plan Year in which the Leave commenced, you will be required to complete the new enrollment process under the Cafeteria Plan by the deadline established by the Plan Administrator, if you want to resume benefit coverage under the Plan for that Plan Year. Your benefit coverage under the Plan will commence as of the date established by the Plan Administrator as provided elsewhere in this Plan document.

3.2.5 Failure to Return to Work. If you fail to return to work with the Employer after your Leave period is exhausted, you will be indebted to the Employer and the Plan Administrator retains the discretion to recover from you the full amount of the cost of any coverage provided to you and your Eligible Family Members under the Plan during such Leave period.

4. ELIGIBILITY AND ENROLLMENT: WHO CAN ENROLL IN THE PLAN AND HOW TO ENROLL

4.1 Eligible Employees.

You are eligible to enroll in this Plan if you are an Eligible Employee. See Section 18, *Definitions*, for a more detailed definition of Eligible Employee, which generally means Eligible Employees who are considered Full-Time Eligible Employees regularly scheduled to work **30 or more hours a week**. However, certain other Employees (like Part-Time, Seasonal or Variable Hour Employees) are excluded. Please carefully review the definition of Eligible Employee and Employee in Section 18 below.

If you initially are not considered by the Plan Administrator to be an Eligible Employee, but are later determined to be an Eligible Employee, you only will be an Eligible Employee prospectively from the date of that determination. If you believe your employment classification has changed from a benefit ineligible to benefit eligible position, you must file a written request with the Plan Administrator to have your employment classification formerly reclassified. Your eligibility to participate in our benefit programs will be on a prospective basis only from the date of the Plan Administrator's final determination to reclassify your employment category.

4.2 Eligible Family Members.

You may enroll your Eligible Family Members, who may include your Spouse and Children, in coverage under this Plan. A detailed description of the eligibility conditions for Eligible Family Members is set forth in Section 18, *Definitions*, under Eligible Family Members, Children and Spouse definitions. The Plan Administrator has full and final discretion to determine if, and require you to verify that, an individual satisfies the eligibility requirements under this Plan and any applicable Supplemental Plan Documents, and to determine whether such Eligible Family Member has been timely enrolled in the manner which satisfies Plan requirements.

There are special rules that apply to the coverage of your Eligible Family Members as set forth below.

4.2.1 Enrollment Requirements. Your Eligible Family Members must be Enrolled in the same Health Plan options in which you are Enrolled. You must timely complete the enrollment process established by the Plan Administrator, including specifically naming the Eligible Family Members and providing their social security numbers for whom you wish to enroll.

4.2.2 Audits of Eligible Family Members . The Plan Administrator may perform periodic Eligible Family Members audits. If your Eligible Family Members are audited, you will be required to provide reasonable documentation (for example, a copy of their birth certificate or a marriage certificate, copies of Social Security cards, a copy of the first page and the signature page of your prior year's federal tax return) proving your Spouse and Children meet the eligibility criteria of the Plan. Failure to provide the requested documentation will result in your Eligible Family Member's loss of eligibility for Plan coverage.

4.2.3 If You and Your Spouse Both Work for the Employer and Both of You Are Active Employees. If you and an Eligible Family Member are Eligible Employees of the Employer, you cannot be Enrolled as both an Eligible Employee and an Eligible Family Member in the Plan.

4.2.4 Newborn Coverage. In the case of birth to an Eligible Employee or Spouse, the newborn Child must be timely enrolled within 30 days of the birth date to have coverage under this Plan effective as of the date of birth. If you do not timely enroll the Child within 30 days of his or her birthdate, you must wait until the next Open Enrollment Period to add your Child to coverage under the Plan, unless there is another Qualified Status Change.

4.2.5 Ineligible Family Members. The Spouse of an Enrolled Child or a child of an Enrolled Child under the Plan is not eligible for coverage under the Plan (unless you qualify as such child's legal guardian, see Section 18, *Definitions*, below).

4.3 Polypore Eligible Retirees and Coverage Provisions.

Notwithstanding anything to the contrary in this Plan or in Supplemental Plan Documents, the following terms govern retiree medical coverage under Plan for eligible retirees.

4.3.1 Closed Program. Eligible Employees who retire, sever or terminate from employment on or after January 1, 2021 shall not be eligible for or enrolled in retiree medical coverage under the Plan.

4.3.2 Eligibility Requirements for Retirees. If you retired prior to January 1, 2021, your retiree medical coverage will continue as an Eligible Retiree, subject to the terms of the Plan. For these purposes, you were considered an "Eligible Retiree" only if you met each of the following requirements:

(A) You severed from employment as a non-union Eligible Employee employed by Polypore International, Inc., Daramic, LLC or Celgard, LLC.

(B) On the date of your severance from employment with the Employer, you had attained the age of 55 with 10 or more years of service.

(C) You were enrolled and participating in medical coverage under this Plan as an active Eligible Employee as of the date of your severance and retirement from employment with the Employer.

(D) You elected to receive retiree medical coverage under the Plan in writing by the date specified by the Plan Administrator, but in no event later than 60 days after you receive the retiree coverage election package from the Plan Administrator. If you failed to timely elect retiree medical coverage, you and your Eligible Family Members will not be eligible to elect or receive retiree medical coverage under the Plan at any later date.

(E) You elect to receive retiree health coverage under the Plan in lieu of, and thus waive, COBRA continuation health coverage under the Plan.

(F) You satisfy all other eligibility requirements set forth in the Supplemental Plan Documents.

4.3.3 Eligibility Requirements for the Retiree's Eligible Family Members. You also were permitted to enroll your Eligible Family Members under the Plan only if each of the following conditions were met:

(A) You are enrolled in the Plan as a Retiree.

(B) Your Eligible Family Member is enrolled and participating in medical coverage under this Plan as of the date of your severance and retirement from employment with the Employer. If you marry or have a Child through birth or adoption after your last day of employment, you will not be permitted to enroll them in the Plan.

(C) You timely enroll Eligible Family Members at the same time you timely enroll yourself for retiree medical coverage.

(D) Your Eligible Family Members elect to receive retiree coverage under the Plan in lieu of, and thus waive, COBRA coverage under the Plan (except as otherwise permitted under the limited circumstances described in Section 4.3.6 below).

4.3.4 Types of Retiree Coverage Available. Retiree coverage under the Plan is available only for group medical benefits. No other welfare benefit described in this Plan document shall be available to you after your retirement, except as otherwise required by COBRA for other group health coverage (like dental, vision or Health FSA).

4.3.5 Contributions. You are solely responsible for the premium cost of retiree medical coverage under the Plan, which will be based on the Medical Plan's COBRA rates (without the 2% administrative fee). You also may be required to share in other costs through deductibles, co-payments and other limitations specified in the Supplemental Plan Documents.

If you fail to timely pay your required contribution, your retiree medical coverage will end and you will not thereafter again resume participation in the Plan as a Retiree.

4.3.6 Termination of Retiree Coverage. Your coverage and/or your Eligible Family Members' retiree coverage under the Plan will terminate under the circumstances and on the dates described in this section (but your Eligible Family Members may have limited COBRA rights as explained in Section 4.3.6 below).

(A) *Medicare Eligibility*. Your coverage (and your Eligible Family Members' coverage) under the Plan will terminate when you become Medicare eligible, even if you do not enroll in Medicare. Please consult with your own advisor regarding when you should timely enroll in Medicare coverage to avoid gaps in coverage or higher Medicare premium payments.

(B) *Failure to Pay Required Contributions*. If you and/or any covered Eligible Family Member fail to timely make any required contributions to the Plan, your coverage and your Eligible Family Member's coverage will be terminated on the date established by the Plan Administrator.

(C) *Eligible Family Members' Coverage*. Your Eligible Family Members' coverage under the Plan will terminate on the earliest of:

(1) the date your coverage terminates for any reason, including attaining age 65, failure to pay premiums, your date of death, etc.;

(2) the date your Eligible Family Member ceases to meet any of the eligibility requirements specified in this Plan (e.g. date of divorce from your Spouse; dependent-child's attainment of the limiting age, etc.).

(D) *Fraudulent Activities*. If you permit, or your Eligible Dependent permits, any other person who is not a qualified member to use any identification card issued by the Claims Administrator or otherwise fraudulently claim a benefit or falsify information on a benefit claim form, the Plan Administrator or Claims Administrator may give you written notice that you (or such other person) are no longer a covered person for benefits under the Plan. If the Plan Administrator or Claims Administrator gives such written notice: you and your Eligible Dependent will cease to be eligible for the benefits under the Plan as of the date specified in such written notice, and no benefits will be paid to you or your Eligible Dependent under the Plan after that date. Any action by the Plan Administrator or Claims Administrator under this provision is subject to review in accordance with the Claims and Claims Review Procedures under the Plan.

(E) *Other Termination*. Your coverage and your Eligible Family Members' coverage under the Plan will end on the date that the Employer terminates, in whole or in part, retiree coverage under this Plan or any other date specified in the Supplemental Plan Documents.

4.3.7 COBRA Coverage. When you retire from employment with the Employer and enroll in retiree medical coverage under the Plan, you are waiving your rights to COBRA medical coverage. At the time of your retirement, you will receive a COBRA Notice and Election package from the COBRA vendor, and, if eligible, you also will receive a retiree medical election package from the Employer. You will have 60 days to decide if you want to enroll in COBRA or retiree coverage. Basically, you will have the following choices:

(A) You many elect COBRA coverage for each group health plan coverage in which you are enrolled as of the date of your retirement as an active Eligible Employee, which may include medical, dental and/or vision coverage. If you and your Eligible Family Members timely elect COBRA medical coverage under this Plan, you will not be eligible for retiree medical coverage under this Plan at any future date.

(B) You may elect retiree medical coverage under this Plan. If you elect retiree medical coverage, you are not eligible for and waive your COBRA medical coverage. However, you and your Eligible Family Members can elect COBRA coverage for any of the other group health plans in which you are enrolled at the time of your retirement (like dental or vision coverage).

(C) Notwithstanding anything to the contrary in this Plan, if your Eligible Family Members' retiree medical coverage is terminated under this Plan because of a qualifying event (such as your death, you becoming eligible for Medicare, divorce from your Spouse or your Child attaining the age of 26 or otherwise not meeting an eligibility condition), the Plan Administrator will offer such Eligible Family Members COBRA coverage under this Plan for a 36-month period beginning on the date of loss of such retiree medical coverage. Except as modified by this Section 4.3, Section 7.2 sets forth the COBRA coverage provisions that apply to you and your Eligible Family Members.

4.3.8 Right to Amend or Terminate. The Employer reserves the right to amend, restate, or modify any retiree coverage and benefits at any time for any reason. The right of the Employer to amend shall specifically include the right to terminate any portion or all of the coverage of any Retiree or Eligible Family Member even if such amendment is made after the retirement or termination of employment of the Retiree. Further, the Employer reserves the right to modify insurers, funding mechanisms, type of coverage, co-payment requirements, deductibles and premium costs and other terms or requirements for retiree coverage as it determines in its sole discretion.

4.4 Effective Date of Coverage.

Except as otherwise provided in the Supplemental Plan Documents for Other Fully-Insured Plans, your coverage under this Plan will begin as follows:

(A) If you are a non-union Eligible Employee, as of the first day of the calendar month immediately following or coincident with your first date of employment as an Eligible Employee.

(B) If you are a union Eligible Employee, your coverage will become effective as of the date specified in the Collective Bargaining Agreement that covers your employment. Please contact the Plan Administrator for further information.

You are automatically Enrolled in basic coverage under the Other Fully-Insured Plans and the Employee Assistance Plan.

FOR ALL OTHER COVERAGE UNDER THIS PLAN, IF YOU FAIL TO TIMELY COMPLETE THE ENROLLMENT PROCESS, YOU WILL NOT RECEIVE COVERAGE UNDER THOSE PLANS FOR THE REMAINDER OF THE PLAN YEAR, UNLESS YOU BECOME ELIGIBLE TO MAKE MID-TEAR ELECTION CHANGE PURSUANT TO A QUALIFIED CHANGE IN STATUS OR SPECIAL ENROLLMENT EVENT OR THE PLAN ADMINISTRATOR IMPLEMENTS DEFAULT COVERAGE ELECTIONS (SEE SECTION 4.6.3 BELOW).

If you are not at work on what would otherwise be your Effective Date of Coverage because of a health condition, your coverage under the Health Plans, as applicable, will still take effect on such date as long as you have been actively at work with the Employer prior to your Effective Date of Coverage. The Supplemental Plan Documents for the Other-Fully Insured Plans may impose actively at work clauses which would delay your Effective Date of Coverage under those plans until you return to active employment with the Employer for the specified period set forth in the Supplemental Plan Documents.

If you timely enroll Eligible Family Members in this Plan at the same time you enroll yourself, their Effective Date of Coverage is the same as yours. If an Eligible Family Member is in a hospital on the date that your enrollment in this Plan is effective, this Plan will become the secondary payer to any other plan covering the Eligible Family Member until the date that he or she is discharged from the hospital. Please also review Section 12, *Coordination of Benefits*, to understand other primary and secondary coverage rules.

4.5 How to Enroll.

The annual enrollment materials will describe the ways to enroll in the Plan during Open Enrollment Period or during your initial enrollment period for new hires.

4.6 Enrollment Process (Which May be Electronic)

4.6.1 Annual Enrollment. Before the beginning of each Plan Year, the Plan Administrator will hold an Open Enrollment Period during which you may elect the type of benefit coverage for the upcoming Plan Year. The enrollment period will begin and end on dates determined by the Plan Administrator. These dates always will be prior to the beginning of the next Plan Year. The law requires that you make your elections before the start of the new Plan Year. Coverage for each benefit elected becomes effective on the January 1 following each enrollment period and the coverage continues until the following December 31. If you fail to timely complete the enrollment process during the Open Enrollment Period, you generally will **not** have any benefit coverage under this Plan for the Plan Year (except as otherwise provided in Section 4.6.3, *Default Elections*, below).

4.6.2 Enrollment for New Employees. When you first become an Eligible Employee, you are required to timely complete the enrollment process by no later than the date established by the Plan Administrator (generally within 30 days of your hire date as an Eligible Employee). Your coverage under the Plan will begin on the Effective Coverage Date and remain in effect for the remainder of the Plan Year. If you fail to timely complete the enrollment process, you will not have any benefit coverage under this Plan for the Plan Year (except as otherwise provided in Section 4.6.3, *Default Elections*, below or in Section 5, *Mid-Year Election Changes*).You then may elect to participate in the Plan for a subsequent Plan Year by making elections during the next Open Enrollment Period.

4.6.3 Default Elections. As explained above, if you fail to timely and properly complete the enrollment process, you will be deemed to have elected no coverage under the Plan for most benefit options. However, the Plan Administrator, at its discretion, may establish a default election procedure under which you may be deemed to have elected one or more benefit options for a Plan Year (or reminder thereof). For example, the Plan Administrator, in its sole discretion, may establish a default election procedure for existing Participants who fail to timely make elections during the Open Enrollment Period that provides they will be deemed to have elected the same elections in effect for the prior Plan Year with respect to all benefits offered under the Plan, other than the Flexible Spending Account Plans. If the Plan Administrator decides to implement default election procedures under the Plan (e.g. for newly hired Eligible Employees or existing Eligible Employees), the Plan Administrator will notify you in writing (e.g., in the annual Employee Benefits Guide) of such default election procedures, including a description of the default elections, the amount of the salary reduction, the period of time for which the election is effective, the procedures to decline coverage and the deadline for making elections. You also are automatically enrolled, without further action, into the basic coverage under the Life Insurance Plan, Business Accident Plan, Long-Term Disability Plan and Employee Assistance.

Notwithstanding these default election procedures, you are required each Plan Year to affirmatively and timely complete any steps/actions established by the Plan Administrator to avoid any wellness surcharges or if you wish to participate in the Flexible Spending Account Plans.

4.7 Reenrollment or Employment Status Changes.

If you terminate employment or have an employment status change that results in a loss of coverage under this Plan, and then return to employment as, or are considered again to be, an Eligible Employee, the following rules apply:

(A) If you are reemployed within 30 days of your termination of employment and the same Plan Year, your previous elections (including elections to decline coverage) will be reinstated as of the first day of the calendar month following your reemployment commencement date and you may not make new elections.

(B) If you are reemployed after 30 days of your termination of employment, you must timely and accurately complete the enrollment process as established by the Plan Administrator under the Plan before any coverage will take effect upon your reemployment. Such timely elected coverage will become effective as of the first day of the calendar month following your reemployment commencement date.

(C) If your employment status changes so that you become an Eligible Employee (e.g., you change from a part-time position to a full-time position), you must timely (e.g. within 30 days of such change in employment status) and accurately complete the enrollment process as established by the Plan Administrator

under the Plan before any coverage will take effect. Such timely elected coverage will become effective as of the first day of the calendar month following your change in employment status.

5. MID YEAR ELECTION CHANGES

5.1 General Rule.

Except as set forth in this Section 5, the elections that you make or are deemed to have made during the enrollment process cannot be changed during a Plan Year (i.e., you may not modify your elections during the Plan Year). For example, your elections regarding participating or not participating in a benefit option, your elected options or tiers of coverage, the amount of pre-tax contributions and similar elections generally are irrevocable for the entire Plan Year.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine if an election change is permissible under this Plan document, the Cafeteria Plan terms and IRS Treasury Regulations. You may request a copy of the formal Cafeteria Plan document for a complete description of Qualified Status Changes and IRS requirements.

5.2 Election Change Procedure.

You must provide notice to the Plan Administrator of a Special Enrollment Event or Qualified Status Change no later than **30 calendar days** following the date on which the Special Enrollment Event or Qualified Status Change occurs (except as otherwise provided in this Section 5.3.3 below regarding Medicaid/CHIP event). If you are permitted to make a change, it will be effective at such time as the Plan Administrator prescribes as set forth in this Section. If you want to change coverage when you experience a Special Enrollment Event or a Qualified Status Change, you must change your benefit elections by contacting the Plan Administrator. The Plan Administrator may require you to certify or provide documentation to determine your eligibility for a Special Enrollment Event or a Qualified Status Change.

5.3 Special Enrollment Events for Health Plans.

5.3.1 Loss of Other Coverage. If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Family Members in the Health Plans, as applicable, within 30 calendar days of the loss of that coverage. The special enrollment generally will become effective on the date established by the Plan Administrator, but in no event later than the first day of the calendar month following the date you timely request and complete the enrollment process (unless the Plan Administrator agrees to delay enrollment to a later date upon your request). For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage. However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Health Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

5.3.2 New Eligible Family Members. You are eligible to enroll yourself and your Eligible Family Members in the Health Plans, as applicable, within 30 calendar days of the date you acquire a new Eligible Family Member through marriage, birth, adoption or placement for adoption. In the case of marriage, the special enrollment generally will become effective on the date established by the Plan Administrator, but in no event later than the first day of the calendar month following the date you timely request and complete the enrollment process (unless the Plan Administrator agrees to delay enrollment to a later date upon your request). In the case of birth, adoption or placement for adoption, the special enrollment becomes effective retroactive to the date of such birth, adoption or placement for adoption, provided your timely request and complete the special enrollment process.

5.3.3 Medicaid/CHIP. You are eligible to enroll yourself and your Eligible Family Member in the Health Plans, as applicable, within 60 calendar days after either:

(A) Your or your Eligible Family Member's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(B) You or your Eligible Family Member is determined to be eligible for premium assistance under Medicaid or CHIP to help pay for coverage under the Health Plan.

Please review Appendix F for more information on Medicaid/CHIP coverage options.

Notwithstanding anything to the contrary in this Section 5.3, the Plan Administrator may extend the applicable notice period (e.g., the 30-day or 60-day period) to the extent necessary to comply with applicable law (e.g., the extended period of time for special enrollment events during the COVID-19 outbreak period) or under such other circumstances determined by the Plan Administrator as administratively necessary.

5.4 Qualified Status Change.

5.4.1 Qualified Status Changes. The following tables briefly describes the events that may be considered a Qualified Status Change. Please contact the Plan Administrator for more details on Qualified Status Changes.

Qualified Status Changes	Applicable Benefit Elections
Seven categories of events: • change in employee's legal marital status • change in number of dependents • change in employment status • dependent satisfies (or ceases to satisfy) dependent eligibility requirements • change in residence • commencement or termination of adoption proceedings • begin or return from a leave of absence	Applies to benefits elections e.g., Health Plans, as applicable, Flexible Spending Accounts, Other Fully-Insured Plans.
Significant Cost Changes	Applies to all benefit elections other than Health FSA
Significant Coverage Curtailment (With or Without Loss of Coverage)	
Addition or Significant Improvement of Benefit Package Option	
Change in Coverage Under Other Employer Plan	
Loss of Group Health Coverage Sponsored by Governmental or Educational Institution	Applies to Health Plans, as applicable, and Health FSA elections
Judgments, Decrees or Orders	Applies to Health Plans, as applicable, and Health FSA elections
Medicare or Medicaid Entitlement	
FMLA Leaves of Absence	Applies to all benefit elections

5.4.2 An Election Change Must Be "Consistent" With the Event. If a Qualified Status Change occurs, a mid-year change in your elections will be permitted only if the Plan Administrator determines that the consistency requirement is met. There is one "general consistency rule" and four "special consistency rules." Briefly, they are—

(A) *General Consistency Rule*. The election change must be on account of and correspond with the Qualified Status Change that affects eligibility for coverage under this Plan. This rule includes two elements that must be met: first, the Qualified Status Change must affect eligibility for coverage under this Plan and, second, the requested election change must be consistent with such Qualified Status Change.

(B) *Special Consistency Rules.*

(1) *Loss of Eligible Family Member's Eligibility; Special COBRA Rules*. For a Qualified Status Change involving your divorce, annulment, legal separation or order of separate maintenance from your Spouse, the death of your Spouse or your Child, or your Child ceasing to satisfy the eligibility requirements for coverage, you may only elect to cancel coverage under the Health Plan, as applicable, for (a) the Spouse involved in the divorce, annulment, legal separation or order of separate maintenance; (b) the deceased Spouse or Child; or (c) the Child that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Qualified Status Change.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Qualified Status Change in which you or your Eligible Family Members gain eligibility for coverage under a cafeteria plan or qualified benefit plan of the Eligible Family Member's employer as a result of a change in marital status or a change in employment status, you may elect to cease or decrease coverage for you, your Spouse, your Child, or any of these, but only if coverage for the person(s) whose coverage is ceasing or being decreased becomes effective or is increased under the Eligible Family Member's employer-plan, as the case may be. The Plan Administrator may rely on your certification that you have obtained or will obtain coverage under the Eligible Family Member's employer's plan or may require you to submit additional documentation before permitted an election change.

(3) *Special Consistency Rule for Dependent Care FSA*. With respect to the Dependent Care FSA, you may terminate your election upon a Qualified Status Change if (a) such change or termination is made on account of and corresponds with a Qualified Status Change that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Qualified Status Change that affects eligibility of Dependent Care Expenses for the tax exclusion under the Code.

5.4.3 Restrictions on FSA Election Changes. Notwithstanding anything to the contrary, the Plan restricts mid-year election changes as follows (even when such changes otherwise would be permissible under the Code):

(A) *Restrictions on Health FSA Elections*. Election changes may not be made to reduce Health FSA coverage already credited to the Health FSA during the Plan Year; however, election changes may be made to cancel Health FSA coverage prospectively due to the occurrence of death of a Spouse, divorce, legal separation, separate maintenance order or annulment, death of an Eligible Family Member, change in employment status such that you become ineligible for Health FSA coverage, or an Eligible Family Member's ceasing to satisfy eligibility requirements for Health FSA reimbursements. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

Any permitted change in an election that increases contributions to the Health FSA also will change the maximum reimbursement benefits for the balance of the Plan Year commencing with the election change. Such maximum reimbursement benefits for the balance of the Plan Year will be calculated by adding:

(1) the contributions (if any) made by you as of the end of the portion of the Plan Year immediately preceding the change in election, to

(2) the total contributions scheduled to be made by you during the remainder of such Plan Year to your Health FSA, reduced by

(3) all reimbursements made during the entire Plan Year.

However, any change in an election as a result of an FMLA leave will change the maximum reimbursement benefits in accordance with Section 9.9.7 below.

(B) *Restrictions on Dependent Care FSA Elections*. If you begin participation in the Dependent Care FSA mid-year or wish to increase your election mid-year as permitted under this Section upon the occurrence of a Qualified Status Change, then you may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. The increased dollar amount will be ratably withheld over the remainder of the Plan Year from your compensation.

Any permitted change in an election affecting annual contributions to the Dependent Care FSA also will change the maximum reimbursement benefits for the balance of the Plan Year (commencing with the election change), but subject to any annual maximum limitations described in Section 9.10 below. Such maximum reimbursement benefits for the balance of the Plan Year will be calculated by adding:

(1) the contributions, if any, made by you as of the end of the portion of the Plan Year immediately preceding the permitted change in election, to

(2) the total contributions scheduled to be made by you during the remainder of such Plan Year to your Dependent Care FSA, reduced by

(3) all reimbursements made during the entire Plan Year.

5.4.4 Effective Date of New Election for a Qualified Status Change. Your new election is effective on and after the Plan Administrator approves your requested election for the balance of the Plan Year (or, to the extent permitted by law, as of the date that the Qualified Status Change event occurs), unless a subsequent event allows for further election changes.

5.5 HSA Changes

You may change your contribution election amounts to your HSA at any time. Any HSA changes are made effective the next applicable pay period after the Plan Administrator processes your election change request.

5.6 Mandatory Mid-Year Changes

At any time prior to or during the Plan Year, the Plan Administrator may require some or all Participants to modify their elections under the Plan if the Plan Administrator determines that such modifications are necessary to preserve the tax-preferred status of the Plan under the Code or due to an increase in the cost of benefits. Specifically, such modifications may include increasing or decreasing your pre-tax elections or completely ceasing your participation in one or more of the benefit options. The Plan Administrator will notify you of any such required modifications.

6. TERMINATION AND EXTENSION OF COVERAGE

6.1 When Your Coverage Ends.

Your coverage and/or your Eligible Family Members' coverage under the Plan generally will end under the circumstances and on the dates described in this Section. However, you may have the opportunity to temporarily extend active coverage under circumstances described in this Section 6 or continue health coverage under COBRA continuation provisions explained in Section 7.2.

6.1.1 Termination of Employment. Except as otherwise specifically provided in this Plan document, Supplement Plan Documents or in a written severance, layoff or other agreement, if your employment terminates, voluntarily or involuntarily (including your unapproved leave of absence or retirement), then your coverage and your covered Eligible Family Members' coverage under the Plan ends at 11:59 p.m. on the date on which your employment terminates.

Notwithstanding anything to the contrary, your employment status will end as of the date you (i) fail to return to work with the Employer after your FMLA leave, USERRA leave or Employer-Approved Leave has ended or (ii) after six months of receiving long-term disability benefits under the LTD Plan (except, in the sole determination of the Plan Administrator, a reasonable work accommodation is required pursuant to applicable disability laws).

6.1.2 Job Classification Change. Except as otherwise specifically provided in this Plan document, Supplement Plan Documents or in a written severance, layoff or other agreement , if you cease to be an Eligible Employee (e.g. due to your hours being reduced below the minimum required by the Employer for coverage), then your coverage and your Eligible Family Members' coverage under the Plan generally will terminate at 11:59 p.m. on the date on which your job classification changes.

6.1.3 Failure to Pay Required Contributions. If you and/or any covered Eligible Family Member fail to timely make any required contributions to the Plan, your coverage and your Eligible Family Members' coverage will be terminated on the date established by the Plan Administrator.

6.1.4 Eligible Family Members. Your Eligible Family Members' coverage under the Plan will terminate on the earliest of:

(A) the date your coverage terminates for any reason; or

(B) at 11:59 p.m. on the date on which in which your Spouse or Child ceases to meet any of the eligibility requirements with respect to the Health Plans, as specified in this Plan document (e.g. on the date a decree, judgment or order of divorce, separate maintenance or legal separation is issued between you and your Spouse, or the date your Child no longer meets the eligibility criteria set forth in this Plan document); provided

however, that your Child's coverage will continue until the last day of the calendar month in which he or she attains age 26.

You must notify the Plan Administrator within 30 days of the date a Spouse no longer is eligible to participate in the Plan as a result of divorce, legal separation, order of separate maintenance or death. You also must notify the Plan Administrator within 30 days of the date a Child no longer is eligible to participate in the Plan as a result of death, attainment of the limiting age or failure to satisfy any other qualifying factor specified under this Plan document. Please carefully review the COBRA provisions in this Plan document regarding your responsibility to timely notify the Plan Administrator when a spouse or dependent is no longer eligible; timely failure to do so will result in a loss of COBRA continuation coverage rights.

6.1.5 Fraudulent, Falsification or Intentional Material Misrepresentation Activities. You and your Eligible Family Members may not perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact. You and/or your dependents may not permit any other person who is not a qualified member to use any identification card issued by the Plan or Claims Administrator or otherwise fraudulently claim a benefit or falsify information on a benefit claim form. The Plan Administrator or Claims Administrator reserves the right to terminate your coverage and your Eligible Family Member's coverage under the Plan, as applicable, either retroactively (to the extent permitted the Health Care Reform Act as described in Section 7.8 below) or prospectively under these circumstances.

The Plan Administrator generally will send to you a written notice that you and/or your Eligible Family Members are no longer covered persons for benefits under the Plan. In this case, you and your Eligible Family Member cease to be eligible for the benefits under the Plan as of the date specified in such written notice, and no benefits will be paid to you and such Eligible Family Members under the Plan after that date. Any action by the Plan Administrator or Claims Administrator under this provision is subject to review in accordance with the Claims and Claims Review Procedures under the Plan.

6.1.6 Other Termination. Your coverage and your Eligible Family Members' coverage under the Plan will end on the date the Employer terminates all or a portion of the Plan providing benefits to you or your Eligible Family Members. Your coverage and your Eligible Family Members' coverage under the Plan also will terminate as of any other date specified in any of the insurance carrier policies.

6.2 Continuation of Coverage during Layoff or Certain Leave of Absence.

Active coverage under this Plan will continue for you and your Enrolled Eligible Family Members even though you are not actively at work, under the circumstances described in this Section 6.2; but subject to the consent of any insurance carriers and your timely remittance of the Premium Payment to the Plan Administrator.

6.2.1 Employer-Approved Leave of Absence. If you are on a Leave which the Plan Administrator determines qualifies as an Employer-Approved Leave of Absence, regular participation in the Plan generally will continue for the duration approved by the Employer during such Leave; provided, however, that you continue to pay your Premium Payment in accordance with Section 3.2, *Premium Payments During Certain Absences*, above. For this purpose "Employer-Approved Leave of Absence" means a leave of absence by you that the Plan Administrator has approved and specifically agreed in writing to continue your active coverage in a particular benefit option offered under this Plan during such leave period.

When an Employer-Approved Leave does not affect your eligibility under the Plan, you are treated as still actively employed for purposes of the participating in Plan and you will not be able to change any elections under Section 5 above. Any debit card(s) shall remain active during the Employer-Approved Leave of Absence.

For purposes of this Plan, "Employer-Approved Leave" will not include any period of time after you fail to return to work following the expiration of your Employer-Approved Leave, or any leave of absence not classified as an Employer-Approved Leave.

6.2.2 FMLA Leave. If you are absent from work due to an approved medical or family leave of absence which is covered under the Family and Medical Leave Act of 1993 ("FMLA Leave"), you generally may elect to:

(A) Prospectively revoke or suspend your health coverage under the Plan during such Leave; or

(B) Continue your election of health coverage under the Plan during the Leave period.

During an FMLA Leave, your health coverage is extended and shall continue on the same conditions and cost terms as are provided for an Employee who is continuously employed during the entire FMLA Leave period, provided you continue to pay your Premium Payment in accordance with Section 3.2, *Premium Payments During Certain Absences*, above.

7. HEALTH PLANS

7.1 Introduction.

This portion of the Plan document describes special rules that apply to coverage under the Health Plans (which, in the aggregate, includes the Medical (medical and prescription benefits), Dental and Vision Plans). This Section of the Plan is to be used in conjunction with the applicable Supplemental Plan Documents for the Health Plans. The Plan Administrator will provide a copy of the summary portions of the applicable Supplemental Plan Document for each of the Health Plans in which you enroll. You also may obtain additional copies of the applicable Supplemental Plan Documents from the Plan Administrator.

7.2 COBRA Continuation Coverage.

7.2.1 General COBRA Rights. Pursuant to COBRA, Enrolled Eligible Employees and their Enrolled Eligible Family Members who cease to be covered under the Health Plans under the same terms and conditions as in effect following the occurrence of certain "qualifying events" (listed below) are eligible to elect continuation coverage under the Health Plans upon payment of a monthly premium.

7.2.2 Qualifying Events. If you are an Employee who is covered by the Health Plans, you will be deemed to have a qualifying event if you lose your coverage because of a reduction in your hours of employment (for reasons other than an FMLA Leave), termination of your employment (for reasons other than gross misconduct on your part) or failure to return to employment following an FMLA Leave (a "qualifying event").

The Employee's Eligible Family Member (including a child born to or placed for adoption with the Covered Employee during a COBRA coverage period) who is covered by the Health Plans, will be deemed to have a qualifying event if he or she loses group health coverage under the Health Plans for any of the following reasons:

(A) The death of the Employee;

(B) Termination of the Employee's employment (for reasons other than gross misconduct), reduction in the Employee's hours of employment (for reasons other than an FMLA Leave), or failure of the Employee to return to employment following an FMLA Leave;

(C) The date a decree, judgment or order of divorce, legal separation or separate maintenance is entered between the Employee and Spouse; or

(D) The Employee becomes entitled to Medicare.

An Employee's Child also will be deemed to have a qualifying event if such Child's group health coverage under the Health Plans is lost because he or she ceases to be an eligible dependent-child under the Health Plans (e.g. he or she attains age 26).

For purposes of the above, a reduction in hours of employment includes any decrease in the number of hours an employee works or is required to work, including a leave of absence, disability or layoff. Rights similar to those described above may apply to retirees, and their Eligible Family Members if the Employer commences a bankruptcy proceeding and these individuals' coverage would be substantially eliminated as a result.

7.2.3 Notice Requirements for Covered Employees and/or Qualified Beneficiaries. The covered employee, his or her covered spouse or dependent child or any representative acting on their behalf must inform the Plan Administrator of the occurrence of each of the following events within the time described below:

(A) A notice of a divorce, legal separation, or a Child losing dependent status under the Health Plans; such notice must be given within 60 days from the date that such qualifying event occurs or the date on which coverage would be lost under the Health Plans because of the qualifying event, whichever is later;

(B) A notice of a second qualified event after the individual has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months; such notice must be given within 60 days from the date that the second qualifying event occurs;

(C) A notice of a determination that an individual (i.e. covered Employee or his or her covered Eligible Family Member) is disabled within the meaning of Title II or XVI of the Social Security Act at any time during the first 60 days of COBRA continuation coverage; such notice must be given within 60 days after the latest of (i) the date of a disability determination by the Social Security Administration, (ii) the date that the qualifying event occurs or (iii) the date on which coverage would be lost under the Health Plans because of the qualifying event; provided, however, that the notice must be given before the end of the first 18 months of COBRA coverage under all circumstances;

(D) A notice of the Social Security Administration's determination that an individual is no longer disabled; such notice must be given within 30 days of the date of such determination; and

Any Notice under this paragraph must be sent in writing by U.S. mail to the Plan Administrator, and must contain the following information:

(1) the name of the covered employee and his or her social security number;

(2) the names of any covered Eligible Family Members;

(3) the identity of each of the Health Plans in which the covered individual(s) participate;

(4) a description of the event that triggers these notice requirements (e.g. the occurrence of a divorce, a child losing dependent status, a disability determination, a second qualifying event (including a description of the second qualifying event)); and

(5) the date on which such event occurred.

The Plan Administrator may require that the notice be supplemented with any additional information as it deems necessary to administer these COBRA provisions. The Plan Administrator may extend the notice deadline set forth above to the extent necessary to comply applicable law (e.g., the extended notice period during the COVID-19 outbreak period). Failure to timely provide written notice to the Plan Administrator under this paragraph will cause you (or your covered Eligible Family Members) to lose the right to receive or extend the period of COBRA coverage.

7.2.4 Employer's Notice of COBRA Rights. The Plan Administrator will notify you of your right or your Eligible Family Member's right to elect continuation coverage (i) after you or your Spouse have notified the Plan Administrator of a divorce, legal separation, or a child losing dependent status, (ii) after you die, terminate employment (for reasons other than gross misconduct), have a reduction in hours of employment (for reasons other than an FMLA Leave), fail to return to employment following an FMLA Leave or become entitled to Medicare, or (iii) in the event the Employer files bankruptcy proceedings and the coverage of retirees, and their Eligible Family Members, if any, is substantially eliminated.

7.2.5 Election of COBRA Coverage. You, or your Eligible Family Members must inform the Plan Administrator that you and/or your Eligible Dependents want continuation coverage within the latest of the following periods:

(A) 60 days from the date your coverage would terminate under the Health Plans by reason of a qualifying event;

(B) 60 days from the date of notice from the Plan Administrator; or

(C) Such later date as required by applicable law (e.g., the extended election period during the COVID-19 outbreak period).

Each Qualified Beneficiary has independent election rights, regardless of his/her original status under the Health Plan; i.e., as an Employee, as a covered Spouse or as a Child. For example, both the Employee and the Employee's Spouse may elect COBRA continuation coverage, or only one of them. Parents may elect COBRA coverage on behalf of their covered Children only. Each qualified beneficiary may elect COBRA coverage on behalf of all other qualified beneficiaries, including on behalf of a minor Child.

If you do not timely elect to purchase COBRA continuation coverage, your group health insurance coverage will end. In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you otherwise are eligible (such as a plan sponsored by your Eligible Family Member's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You also will have the same special enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you.

7.2.6 COBRA Coverage. If continuation coverage is chosen, the Employer is required to give you coverage which, at the time coverage is provided, is identical to the coverage provided under the applicable Health Plans to similarly situated non-COBRA employees or family members. This will include the same right to make changes to your coverage options during an Open Enrollment Period to the same extent offered to active Employees. Health Plan changes (increases or decreases in benefit levels or costs), Open Enrollment Periods, and change in life status requirements apply to qualified beneficiaries who are continuing coverage when the plan change is made. A few special rules apply:

(A) Each qualified beneficiary is entitled to make separate elections at the time of the qualifying event or a subsequent Annual Enrollment Period. A separate premium billing will be applicable to each separate election.

(B) Qualified beneficiaries will be subject to changes in the terms of the applicable Health Plan (e.g., increases or decreases in benefit levels or costs), requirements and rights involving Annual Enrollment Periods, and restrictions and rights regarding change in life status requirements that otherwise apply under the terms of the Health Plans to other Plan Participants.

(C) COBRA only applies to the traditional health care coverage component of the Health Plans. With respect to the HDHP-HSA options offered under this Plan, the HSA portion will not be subject to COBRA law. Therefore, any Employer contributions to a HSA will cease as of your last day worked as an Employee of the Employer, even if you elect to continue coverage under the HDHP option through COBRA. Non-group health benefit options offered under this Plan document (e.g. Dependent Care FSA, LTD Insurance and Life Insurance) are not subject to the COBRA continuation coverage provisions.

7.2.7 Cost of COBRA Continuation Coverage. If continuation coverage is chosen, you and/or your Eligible Family Members must pay premiums to the Plan Administrator. The amount of the monthly premium for such continuation coverage will be determined by the Plan Administrator, but in no event will it be greater than 102% (150% in the case of a disabled individual and his or her non-disabled family members) of the applicable premium as determined pursuant to COBRA (the "applicable premium"). The amount of the applicable premium will be determined on a yearly basis, but you and/or your Eligible Family Members are entitled to pay the applicable premium in monthly installments.

(A) Payments for COBRA Continuation Coverage must be made by check or money order, payable to the Claims Administrator identified in Appendix B and by the timeframes described in this section, except as otherwise required by applicable law (e.g., the extended payment timeframe during the COVID-19 outbreak period). The Claims Administrator must receive the first payment within 45 calendar days after the date it receives the election form. From then on, payments are due on the first day of each month for which coverage is to be continued. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 calendar days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided each month as long as your payment is received before the end of the grace period for the payment.

(B) If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Health Plans.

(C) If you do not make your first payment for COBRA coverage in full within 45 calendar days after the date of your election, you will lose all COBRA rights under the Health Plans.

7.2.8 General Duration of COBRA Coverage. The law requires that you be afforded the opportunity to maintain continuation coverage for:

(A) 18 months after the date of the qualifying event that caused your spouse or dependent child to lose coverage because of a termination of employment (for reasons other than gross misconduct), reduction in hours (for reasons other than an FMLA Leave) or failure to return to employment following an FMLA Leave; or

(B) 36 months after the date of all other qualifying events that caused you to lose coverage under the applicable Health Plans.

The coverage period of a child who is born to or placed for adoption with you during a period of continuation coverage is measured from the date of the qualifying event which caused you to lose coverage under the Health Plans (and not from the date of the birth or placement for adoption).

7.2.9 Extended Period of COBRA Coverage. If you elect continuation coverage, an extension of the maximum 18-month period of coverage may be available if a qualified beneficiary is disabled or experiences a second qualifying event, as described below. You must notify the Plan Administrator of a disability or a second qualifying event in accordance with the notice requirements set forth above.

(A) *Second Qualifying Event.* The 18-month period (for Spouse and dependents) may be extended to 36 months if other events (e.g., divorce, legal separation, death, Medicare entitlement, or loss of dependent child status) occur during the initial 18-month period.

If you become entitled to Medicare and within 18 months thereafter lose coverage due to a termination of employment, reduction in hours or failure to return to work after the end of an FMLA Leave period, your Spouse and/or dependent children will be entitled to continuation coverage for a total of 36 months from the date you become entitled to Medicare. The Qualified Beneficiary must notify the Plan Administrator of a second qualifying event in the manner and by the time set forth in paragraph (c) above.

(B) *Disability*. The 18-month period also may be extended to 29 months by an individual (i.e. by you or your Eligible Family Member) who is determined to be disabled within the meaning of Title II or XVI of the Social Security Act at any time prior to or during the first 60 days of COBRA continuation coverage, and by any individual who became eligible for continuation coverage under this Section with respect to the same qualifying event as the disabled individual (i.e., a non-disabled family member). A disabled individual (and his or her non-disabled family members who are entitled to continuation coverage) must notify the Plan Administrator in the manner and by the time set forth in paragraph (c) above. In addition, the Plan Administrator must be notified within 30 days of any final determination that the individual is no longer disabled. For the additional 11-month period, the cost of coverage will be not greater than 150% of the applicable premium, provided that the disabled individual is included in that coverage. If the disabled individual does not elect continuation coverage, the cost of coverage will not be greater than 102% of the applicable premium. The 29-month period may be extended to 36-months for an Eligible Family Member if another qualifying event (e.g., divorce, legal separation, death, loss of dependent child status) occurs during the 29-month period.

If such other qualifying event occurs during the first 18 months of continuation coverage, the cost of coverage will not be greater than 102% of the applicable premium. If such other qualifying event occurs after the first 18 months of continuation coverage (and before the expiration of the 29-month period), the cost of coverage will not be greater than 150% of the applicable premium, provided that the disabled individual is included in that coverage. The Qualified Beneficiary must notify the Plan Administrator of a second qualifying event in the manner and by the time set forth in paragraph (c) above.

7.2.10 Termination of COBRA Coverage. Continuation coverage will terminate on the earliest of:

(A) the date the maximum period of continuation coverage is completed (i.e. the expiration of the 18-, 29- or 36-month period as described above);

(B) the date the COBRA continuee is covered under another group plan (other than a group health plan under which the person was covered prior to electing COBRA continuation coverage), if that plan does not contain an exclusion or limitation for a pre-existing condition of such individual or which does contain an exclusion or limitation as to any preexisting condition, but such exclusion or limitation does not apply to or is satisfied by the employee, spouse or dependent child, as applicable, by reason of applicable law or otherwise;

(C) the date the COBRA continuee's applicable premium for continuation coverage is not timely paid;

(D) the date the COBRA continuee becomes entitled to (i.e. actually enrolled in) Part A or B of Medicare (provided the entitlement to Medicare first arises after COBRA continuation coverage has been elected);

(E) if there has been an 11-month extension of coverage due to a COBRA continuee's disability, coverage during the 11-month extension period shall terminate following the date there has been a final determination that such individual is no longer disabled (in such case, coverage shall terminate for all individuals who were entitled to the 11-month extension as a result of the disability); or

(F) the date the Employer ceases to provide any health plan coverage to any Employee.

7.2.11 Marketplace Coverage as an Alternative to COBRA. As explained above, when you lose your coverage under the Health Plans by reason of a COBRA qualifying event (e.g., your employment termination), you temporarily can elect to continue that coverage under the applicable Health Plans at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your Spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e. tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g. through your Spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will not later have the right to elect COBRA coverage under the Health Plans. If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy.

For example, if you enroll in COBRA coverage under one or more of the Health Plans, but decide mid-year that you want to drop that coverage because it is not affordable to you, most Claims Administrators will not permit you to enroll in an individual health insurance policy until the next Annual Enrollment Period. This restriction applies even though COBRA is no longer affordable to you (e.g. when your financial situation changes or a COBRA subsidy from the Employer or other source ends).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the Plan Administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the Health Plans' COBRA Notices.

7.2.12 Trade Preferences Extension Act of 2015. The Trade Preferences Extension Act of 2015 reinstated the Health Coverage Tax Credit for certain individuals who become for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals may be entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period of 60 days or less (but only if the election is made within six months after plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, Please contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect cobra during a special second election period. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282 (TTD/TTY). More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

7.2.13 Keep the Employer Informed of Address Changes. To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You also should keep a copy of any notices, election or payments you send to the Employer or Plan Administrator regarding your COBRA continuation coverage.

7.3 Continuation Coverage during a USERRA Leave.

If you are on a qualified military leave of absence under USERRA, you may continue coverage during your USERRA Leave, as follows:

7.3.1 Short-Term USERRA Leave. If you are on a USERRA Leave which is less than 30 days, you and your dependents may continue to participate in the applicable Health Plans for an additional 30 days beyond the date on which your Leave begins. Coverage during this 30-day period will be at the premium rates you would have been charged if you remained actively employed with the Employer during this 30-day period.

7.3.2 Long-Term USERRA Leave. If you are on a USERRA Leave which extended beyond 30 days, you and your Eligible Family Members may elect to continue coverage under one or more of the applicable Health Plans for the lesser of:

(A) The 24-month period beginning on the date your USERRA Leave begins.

(B) The date after you fail to apply for or return to a position of employment, as determined under USERRA.

(C) The date you fail to pay the required premium for such coverage. The required premium for continued coverage under the applicable Health Plan for a USERRA Leave period extending beyond 30 days is 102 percent of the entire premium cost for coverage under the applicable Health Plan.

You must elect to continue coverage under the Health Plans during your USERRA Leave in the manner and by the deadline established by the Plan Administrator (which will be similar to COBRA election process of electing continuation coverage within the 60-day COBRA election period).

Your share of the premium cost of continued coverage under the applicable Health Plans during your USERRA Leave must be paid in accordance with the rules outlined in Section 3.2, *Premium Payments During Certain Absences*, above.

If you are reemployed with the Employer pursuant to USERRA, your coverage under the Health Plans will be reinstated immediately without any waiting periods. If you are reemployed and are currently covered under the Health Plans, those elections shall continue to apply following your reemployment. If you are reinstated and are not currently covered under the Health Plans on your reemployment dates, you must timely complete the enrollment process within 30 days of your reemployment date to elect coverage under the Health Plans. After the 30-day period, you will not be permitted to elect coverage until the next Annual Enrollment Period (unless otherwise permitted under the terms of this Plan document and the Cafeteria Plan (e.g. you experience a mid-year qualifying change in status event).

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is not able to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer for representation. You also may bypass the VETS process and file a claim under the applicable Health Plan's internal claims review and appeal procedures or bring a civil action for violations of USERRA.

7.4 Rights under Michelle's Law.

Since 2011, the Medical Plan no longer conditions the medical coverage of an Enrolled Child who is under the age of 26 on the child maintaining student status. As a result, Michelle's Law has no further relevance to the Medical Plan. Prior to 2011, the Medical Plan complied with Michelle's Law (which generally prohibited the Medical Plan from terminating coverage for a dependent student who takes a medically necessary leave of absence).

7.5 Benefit Authorization Procedures, PPO Information, Wellness Initiatives and Patient Protections.

7.5.1 Authorization Procedures. Certain benefits under the applicable Health Plans may require prior authorization before those benefits will be covered under the applicable Health Plans. The Supplemental Plan Document lets you know when prior authorization is required. The Supplemental Plan Document also describes the procedures for obtaining this prior authorization.

7.5.2 PPO Information. If the Supplemental Plan Document specifies that a particular benefit program is offered through a Preferred Provider Organization (PPO) or Network system, this means that you are offered a choice to utilize either designated health care providers or non-designated health care providers. If you (and your

covered Eligible Family Members) use designated health care providers, you generally will experience a higher level of benefits (i.e. at lower cost to you) than if you use non-designated providers. Benefit levels for in-network and out-of-network services are outlined in the Supplemental Plan Document. A listing of designated health care providers is available at no charge through the Claims Administrator for the applicable PPO (identified in the Appendix B or applicable Supplemental Plan Documents that apply to your Employee Group).

In the case of PPO arrangements, the Claims Administrator requires in its contracts with the health care providers that each provider meet all applicable licensure requirements. The applicable Health Plans, however, do not supervise, select or control the network providers or assume liability for their activity or treatment of you, and, thus, you should carefully select your health care providers. You also are solely responsible for verifying whether a particular provider is in-network by calling the Claims Administrator identified in the Supplemental Plan Document (and Appendix B) for a particular benefit program that is offered through a PPO (you should not solely rely on a provider's representation for network verification).

7.5.3 Wellness Initiatives. The Employer, at its sole discretion, may implement certain wellness initiatives and rewards for Eligible Employees to encourage healthy life choices. The Plan Administrator will furnish you with information during each Open Enrollment Period regarding any available wellness initiatives and rewards and the enrollment process for taking advantage of such program. If you fail to timely complete the enrollment process, you may not be eligible for the program for that Plan Year. If you fail to timely satisfy any requirements of the program, you may forfeit the right to continue your participation in and/or receive any available rewards under the wellness program for the remainder of the Plan Year.

If you reasonably believe you are unable to participate in any wellness initiative, please contact the Plan Administrator as reasonable alternative standards or goals to achieve a reward may be available to you under the wellness initiative.

7.5.4 Patient Protection Rights. Please review Section 7.8, *ACA Health Care Reform*, below, which explains certain patient protection rights in selecting providers and emergency room services under the Medical Plan.

7.6 Rights Under the Newborns' and Mothers' Health Protection Act.

Under federal law, the Medical Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

(A) 48 hours following a vaginal delivery; and

(B) 96 hours following a delivery by cesarean section.

However, the Medical Plan may pay for a shorter stay if the attending provider (e.g., your physician) after consultation with the mother, discharges the mother or newborn earlier. Also, the Medical Plan may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Medical Plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-approval. For information on pre-approval, refer to the Supplemental Plan Document that applies to the health care option elected.

7.7 Women's Health and Cancer Rights Act.

Consistent with the recent Women's Health and Cancer Rights Act, the Medical Plan provides the following benefits in connection with a Medical Plan covered mastectomy:

(A) Reconstruction of the breast on which the mastectomy was performed.

(B) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

(C) Prostheses and coverage for physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The manner in which the above services will be performed will be determined after consultation with the physician and patient. Coverage for the above services will be subject to deductibles, co-payments and other limitations that are consistent with those that apply to other benefits under the Medical Plan.

7.8 ACA Health Care Reform Changes.

The Patient Protection and Affordable Care Act ("PPACA") was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act") was enacted on March 30, 2010, (collectively referred to as the "Health Care Reform Act"). The provisions below describe the market reform provisions that apply to the Medical Plan, but these provisions are subject to and hereby incorporate by reference any additional guidance issued by the IRS, DOL or Health and Human Services agencies. The Dental and Vision Plans are provided under a separate plan arrangements, which are not integral parts of the Medical Plan. As a result, the Dental and Vision Plans are not subject to the market reform provisions of the Health Care Reform Act described in this Section 7.8.

7.8.1 Continued Eligibility for Children Until Age 26. Notwithstanding anything to the contrary in the Supplemental Plan Document, the Medical Plan shall comply with the provisions of the Health Care Reform Act regarding the continued eligibility of children until age 26. Under the Health Care Reform Act, if the Medical Plan permits an Eligible Employee to enroll his/her Child for coverage, the Child must be permitted to continue such coverage until attainment of 26 years of age. The Medical Plan shall not condition a Child's eligibility for dependent coverage on the basis of marital, financial dependency, residency, student, or employment status, or eligibility for other coverage (except as provided below), and shall not vary the terms of the Medical Plan based on the age of a Child. However, the Medical Plan may define the necessary relationship between the Eligible Employee and the Child for such Child to be eligible for coverage under the Medical Plan. The Medical Plan may continue to require financial dependency and other conditions on Children over the age of 26 (e.g. with respect to a Disabled Child over the age of 26, the Plan may still require such Child to be financially dependent on the Employee).

The Medical Plan requires that an Eligible Employee's Child be enrolled in the same benefit package options as elected by the Eligible Employee and that such Child continues to satisfy the eligibility and enrollment conditions as set forth in this Plan document.

7.8.2 Lifetime and Annual Limitations. The lifetime and/or annual limits on the dollar amount of benefits for any Eligible Employee or Eligible Family Member covered under the Plan no longer apply. If your coverage (or your Eligible Family Member's coverage) ended by reason of reaching a lifetime limit under the Medical Plan, you are eligible to re-enroll in the Medical Plan. Notwithstanding these restrictions:

(A) The Medical Plan may impose annual or lifetime dollar limits, with respect to any covered individual, on specific covered benefits that are not essential health benefits, to the extent that such limits are otherwise permitted under applicable law.

(B) The Medical Plan may exclude entirely all benefits for a certain condition (except as otherwise required by applicable law) (i.e. exclude benefits for a certain type of condition or treatment, but if any benefits are provided for such a condition or treatment, then the Medical Plan must comply with the prohibition on such lifetime and annual limits).

For these purposes, the term "essential health benefits" has the meaning ascribed to it under the Health Care Reform Act and related regulations, and include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral treatment; prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. For Plan Years beginning before the issuance of regulations, the Medical Plan shall use good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" and must apply the definition consistently.

7.8.3 Limitations on Coverage Rescission. Your group health coverage under the Medical Plan may not be rescinded, unless you or your Eligible Family Member performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Medical Plan. The Medical Plan must provide at least 30 days advance written notice to you and any Eligible Family Member who would be affected before coverage may be rescinded. Any cancellation or discontinuance of medical coverage that has retroactive effect shall be subject to the Medical Plan's internal claims review and appeal process as set forth under Section 18, *General Claims Review And Appeals Procedures*, below.

For these purposes, a rescission of coverage means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission protected by this provision if (i) the cancellation is applied prospectively; (ii) it is applied retroactively, but results from your failure to timely pay premiums or contributions towards the cost of coverage (iii) the Plan erroneously covers your ex-spouse because you or your ex-spouse failed to timely report a divorce, legal separation or order of separate maintenance to the Plan Administrator; (iv) the Plan erroneously covers you or a dependent due to a reasonable administrative delay in terminating coverage; or (v) any other circumstance under which retroactive termination would not violate the ACA.

7.8.4 Prohibition on Pre-Existing Condition Exclusions. The Medical Plan may not impose pre-existing condition exclusions on you or your Eligible Family Members.

7.8.5 Waiting Periods. The Medical Plan shall not impose a waiting period in excess of 90 calendar days, with coverage becoming effective no later than the 91st calendar day after the waiting period first began. A waiting period is the period of time that must pass before coverage of an Eligible Employee and/or Eligible Family Members can become effective. Any waiting period imposed under the Medical Plan shall be subject to the rules set forth below and consistent with the regulatory guidance under the Health Care Reform Act, which is incorporated by reference herein.

(A) All calendar days shall be counted beginning on the first day the waiting period commenced, including weekends and holidays.

(B) Any additional period of time taken by an Eligible Employee to properly complete the enrollment process (including any period before a late or special enrollment period) shall not be counted toward this 90-day waiting period limitation.

(C) A former Employee who is rehired may be treated as newly eligible for coverage upon rehire date and, therefore, may be required to meet the Medical Plan's eligibility criteria and to satisfy the waiting period anew, as long reasonable under the circumstances (e.g. the termination and rehiring of the Employee cannot be a subterfuge to avoid complying with these waiting period rules). The same analysis may apply to an Employee who moves to a job classification that is ineligible for coverage under the Medical Plan but then later moves back to an eligible job classification.

(D) The Plan Administrator, at its sole discretion or pursuant to a Collective Bargaining Agreement, may impose substantive eligibility conditions (other than those based solely on a lapse of time) under the Medical Plan. This Plan document together with the Supplemental Plan Document will set forth any additional substantive eligibility conditions, which must be consistent with regulatory guidance under the Health Care Reform Act, including, but not limited to the following rules:

(1) The Medical Plan may continue to impose eligibility conditions based on eligible job classifications (e.g. may exclude Employees classified as part-time Employees, as employed at certain locations or as covered under certain collectively bargaining agreements, etc.).

(2) If the Plan Administrator cannot determine that a newly-hired Employee is reasonably expected to regularly work the specified number of hours to be treated as an Eligible Employee as of his/her date of hire, the Plan Administrator may take a reasonable period of time, not exceeding 12 months and beginning on any date between the Employee's start date of employment and the first day of the first calendar month following the Employee's start date, to determine whether such an Employee meets the eligibility conditions. If the Plan Administrator determines during this period that the Employee regularly works the specified number of hours to be eligible for coverage, such Employee must be permitted to enroll in the Medical Plan no later than the first day of the calendar month coincident with or next following 13 months from the Employee's start date of employment.

(3) The Medical Plan also may require an Employee to complete a number of cumulative hours-of-service before becoming eligible for coverage, but not in excess of 1,200 hours-of-service. Upon an Employee's completion of the specified cumulative hours-of-service, his or her coverage under the Medical Plan must become effective no later than the 91st calendar day after the date on which such cumulative hours-of-service requirement has been completed. Any such hour-of-service requirement shall be structured as a one-time eligibility condition and cannot be re-applied during the Employee's employment (e.g. cannot require the Employee to satisfy the hour-of-service requirement within a specified period of time (e.g. within one plan year).

(4) The Medical Plan also may impose a bona-fide, employment-based orientation period. To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an Employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an Employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the Employee's start date Is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the Employee's start date is August 31,the last permitted day of the orientation period is September 30.

7.8.6 Recommended Preventive Services. The Medical Plan shall provide coverage for all "recommended preventive services" and may not impose any cost-sharing requirements (e.g. deductibles, coinsurance or copayments) to Eligible Employees and Eligible Family Members with respect to such preventive services. The term "recommended preventive services" shall have the meaning ascribed to it under the Health Care Reform Act's related regulations which are incorporated by reference.

A list of items or services that are considered recommended preventive services can be found at http://www.HealthCare.gov/center/regulations/preventive.html, which include women's preventive services. Any new recommended preventive service also will be noted on this site; the Medical Plan must modify its terms to include coverage with no cost-sharing requirements for any newly recommended preventive services as of the first Plan Year beginning on or after the date that is one year after the new recommendation went into effect or such earlier date as required by law (e.g., COVID-19 vaccinations shall be covered at no cost within 15 business days of the date the recommendation is released).

The Medical Plan is not required to provide coverage and/or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service, or if such item or service is delivered out-of-network. If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, the Medical Plan may impose cost-sharing on the office visit. If the recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a recommended preventive service, the Medical Plan may not impose cost-sharing requirements with respect to the office visit. However, if the recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a recommended preventive service, the Medical Plan may impose cost-sharing requirements with respect to the office visit.

7.8.7 Patient Protections. The Medical Plan shall comply with the patient protection provisions of the Health Care Reform Act, as follows:

(A) You will have the right to designate any primary care provider who participates in the Medical Plan's network and who is available to accept you and/or your Eligible Family Members. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Medical Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Medical Plan of treatment decisions.

(B) If you do not make a provider designation, the Medical Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the Plan Administrator or the Claims Administrator identified in the Supplemental Plan Document or Appendix B.

(C) To the extent the Medical Plan provides any benefits with respect to services in an emergency department of a hospital, such option must provide emergency services (i) without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis; (ii) without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; (iii) if the emergency services are provided out-of-network,

without imposing any administrative requirement or limitation on coverage this is more restrictive than the requirements or limitations that apply to emergency services from in-network providers; (iv) if the emergency services are provided out-of-network, without imposing cost-sharing requirements of copayments and/or coinsurance that exceed those that apply to emergency services provided by an in-network provider (other than as permitted under the Health Care Reform Act's related regulations); and (v) without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted by law, or applicable cost sharing. Any cost-sharing requirement, other than copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum), may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

7.8.8 New Appeal and External Review Claims Procedures. In addition to the claims procedures set forth in this Plan document and the Supplemental Plan Documents, a benefit option offered under the Medical Plan shall comply with the Consumer Appeal Rights under the Health Care Reform Act, which are incorporated by reference herein and further set forth in the Claims Review and Appeal Procedures of this Plan document.

7.9 Changes by Plan Administrator to Meet Federal Requirements.

The Plan is legally required to meet certain federal rules which prevent group Health Plans from favoring highly compensated individuals as to eligibility to participate or with respect to benefits. If the Plan fails to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees (as defined by Code Section 416), the Plan Administrator may take appropriate action including modifying benefit elections made by highly compensated individuals or key employees. The Plan Administrator reserves the right to disaggregate the Health Plans into separate component plans for purposes of performing nondiscrimination testing under the Code.

7.10 Qualified Medical Child Support Orders ("QMCSO").

If the Plan Administrator receives written evidence of any medical child support order applicable to you, the Plan Administrator will promptly notify you and each alternate recipient named in the order of its receipt and of the Plan's procedures for determining whether the order is qualified under Section 609 of ERISA. In the event that an order is determined to be qualified, the Plan Administrator will take whatever action is necessary to ensure that the terms of the order are carried out, including, without limitation, modifying your benefit elections.

Please review Appendix E which sets forth the Plan's QMCSO procedures.

7.11 Genetic Information Nondiscrimination Act of 2008 (GINA).

GINA prohibits the Employer and the Health Plans from:

(A) Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;

(B) Adjusting your premium and contribution amounts on basis of genetic information;

(C) Requesting or requiring you or a family member to undergo a genetic testing;

(D) Requesting, requiring or purchasing genetic information for underwriting purposes; or

(E) Requesting, requiring or purchasing genetic information about an individual prior to or in connection with an individual's enrollment under the plan

GINA also makes it illegal for the Employer to discriminate against you with respect to your compensation or the terms, conditions or privileges of employment on the basis of your genetic information and from collecting such data (except as otherwise permitted for certain wellness programs of the Employer).

7.12 Mental Health Parity Act ("MHPA").

If the Medical Plan provides benefits for mental health or substance abuse disorders, the MHPA requires equal treatment of mental health and substance abuse benefits in parity with medical/surgical benefits. This generally means that:

(A) Financial requirements and treatment limits applicable to mental health and substance abuse are no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coins, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);

(B) Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance abuse; and

(C) Criteria for medical necessity and reason for claim denials must be made available.

The Supplemental Plan Document for the Medical Plan will provide an explanation of the covered and excluded benefits, which will comply with the Mental Health Parity Act.

7.13 Surprise Bill Protections.

Starting January 1, 2022, there are new billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Through new rules aimed to protect you, excessive out-of-pocket costs will be restricted, and emergency services must continue to be covered without any prior authorization, and regardless of whether or not a provider or facility is in-network. Please review Appendix G for more information regarding your rights under this new federal law. Some states also have enacted similar surprise billing protection laws. The Medical Plan, as a self-funded medical plan, will comply with the federal laws, but ERISA preempts and makes the Medical Plan exempt from the state laws.

8. OTHER FULLY-INSURED PLANS

8.1 Introduction.

The Employer sponsors fully-insured Short-Term Disability Plan, Long-Term Disability Plan, Group Term Life and AD&D Plan and Business Travel & Accident Insurance (in the aggregate "Other Fully-Insured Plans") to provide Eligible Employees with short-term and long-term disability insurance, and basic and supplemental/voluntary group-term life and accidental death and dismemberment insurance and business travel and accident insurance benefits. This portion of the summary is to be used in conjunction with the applicable Supplemental Plan Document for the Other Fully-Insured Plans. The Plan Administrator will provide a copy of the applicable Supplemental Plan Document to you when you become a Participant in one or more of the Other Fully-Insured Plans. You also may obtain a copy of the Supplemental Plan Document by contacting the Plan Administrator.

8.2 Supplemental Plan Documents.

The Other Fully-Insured Plans are solely governed by the applicable Supplemental Plan Document prepared by the Claims Administrator and all benefits payable under such Supplemental Plan Document is the sole liability and responsibility of the Claims Administrator identified in Appendix B, and not the Employer. If the terms of this Plan document conflicts with the terms of the Supplemental Plan Documents for the Other Fully-Insured Plans, the Supplemental Plan Documents control, unless superseded by applicable law.

8.3 Facility of Payment.

If the Plan Administrator determines that you are incapable of receiving any disability benefits under the Plan that you are entitled to receive because you are ill, or otherwise incapacitated, the Plan Administrator may direct that payment be made on your behalf.

8.4 Conversion Rights.

Please refer to the accompanying Supplemental Plan Document to determine if you are eligible to convert your coverage to an individual policy after your group coverage under the Plan terminates. It is your sole responsibility to timely contact the Claims Administrator for information about the availability of this conversion coverage and the rules concerning your eligibility for conversion coverage when you group coverage ends under this Plan.

8.5 Lost Distributees.

If the Plan Administrator is unable to locate you or your beneficiary when your benefit is due, your benefit will be deemed to be forfeited. Therefore, it is important that you keep the Plan Administrator informed of any changes to your current address.

8.6 Right of Verification.

If you omit or provide any false information on your benefit claim form, you may be disqualified from receiving benefits under the Plan. In addition, you may be subject to disciplinary action and/or termination of employment.

8.7 Right of Recovery.

If the amount of disability benefits that you receive exceeds the maximum amount that is payable under the Plan, the Plan Administrator will have the right to recover the excess payments from you.

8.8 Taxation of Benefits.

The tax consequences to you for coverage under the short-term and long-term disability coverage depend on who pays for the premiums. When the Employer pays for the entire premium cost of your short-term or long-term disability coverage and the Employer does not include such cost in your taxable income for the taxable year, then, if you actually become disabled and receive disability payments, you will be subject to income tax on such disability payments. However, if the Employer pays for your coverage and does include such cost in your taxable income for the taxable year, if you actually become disabled and receive disability payments from such disability plan, you will not be subject to income tax on such disability payments. Please contact the Plan Administrator to determine the tax consequences to you of this coverage.

With respect to group term life insurance, typically the cost of up to $50,000 of group term life insurance paid by the Employer will not be included in your gross income for federal tax purposes. If your life insurance coverage exceeds $50,000, then the cost of such coverage in excess of $50,000 will be included in your gross income for tax purposes.

Any income or employment taxes that result from the provision or payment of benefits under the Other Fully-Insured Plans are your sole responsibility; the Employer does not guarantee and shall not be responsible for any particular tax consequences. Please consult your own tax advisor if you have questions regarding the taxation of your disability benefits and/or life insurance benefits.

9. FLEXIBLE BENEFITS PLAN

9.1 Introduction.

This Section describes your rights and benefits under the Cafeteria Plan. These provisions are to be used in conjunction with the formal Cafeteria Plan document prepared by the Plan Administrator and any applicable Supplemental Plan Documents prepared by the Claims Administrator. You may obtain a copy of the formal Cafeteria Plan document and another copy of any applicable Supplemental Plan Documents by contacting the Plan Administrator.

9.2 Type of Plan.

The Cafeteria Plan is a cafeteria/fringe benefit plan, as described in and governed by Section 125 of the Internal Revenue Code (the "Code"). The Health FSA is a welfare benefit plan as described in Section 3(a) of the Employee Retirement Income Security Act ("ERISA") and a group health care plan as described in Code Section 105. The Dependent Care FSA Plan is a dependent care assistance plan as described in Code Section 129.

9.3 Purpose of the Cafeteria Plan.

The Cafeteria Plan allows you to set aside "before-tax" dollars from your gross pay (i) for contribution to your own health and dependent care spending accounts to be used by you for reimbursement for certain medical and dependent care expenses, (ii) for payment of your share of certain insurance premiums (iii) for contribution to a health savings account (within the meaning of Code Section 223) and (iv) opt-out cash payment feature (if available to your Employee Group). Because you can pay for these expenses with before-tax dollars, you pay no federal income taxes

or social security taxes on the dollars that you set aside. In other words, you can trade before tax income for tax free benefits.

Prior to the beginning of each Plan Year, the Plan Administrator will notify you of the benefits available for selection under the Cafeteria Plan for such following Plan Year.

9.4 Conditional Opt-Out Cash Payment Feature.

Through the Cafeteria Plan, you may elect to receive a taxable opt-out cash payment in lieu of enrolling in medical coverage under this Plan. The opt-out cash payment is subject to the following terms and conditions:

(A) You must certify in writing that you and each Eligible Family Member are enrolled in other medical coverage.

(B) You agree in writing that you are waiving medical coverage under this Plan and understand that such election cannot be changed during the Plan Year, unless you have a qualifying change event (see Section 5 above).

(C) The Plan Administrator, in its discretion or as otherwise set forth in a Supplemental Plan Document, shall determine the annual dollar amount of the opt-out cash payment for the Plan Year and how it will be paid to you (e.g., ratably over each pay period).

9.5 Mid-Year Changes in Benefit Elections.

The elections that you make through the Cafeteria Plan are required by law to be irrevocable during a Plan Year (i.e., you may not modify those elections during the Plan Year), except under limited circumstances permitted by law, the Cafeteria Plan terms and this Plan document. Please review Section 5 regarding when change may be permitted, as determined in the sole discretion of the Plan Administrator.

9.6 Termination of Coverage.

Participation under the Cafeteria Plan generally will end upon your termination of employment or when you cease to timely pay your required contributions to the Cafeteria Plan. In some cases, you may elect to continue participation in the Cafeteria Plan following termination of employment, or during certain leaves of absences, but your participation may be on an after-tax basis. Please see Sections 7.2 and 9.6 regarding COBRA Continuation Coverage rights which applies to the Health FSA. Please also review Section 9.9.5 below regarding certain spend down rights under the Dependent Care FSA.

If you are rehired within 30 days of your termination of employment, you may begin to participate in the Cafeteria Plan again upon satisfying the eligibility requirements, but your previous elections will apply and you may not make new elections for the same Plan Year in which you terminated employment. See Section 4.7, *Reenrollment or Employment Status Change*, above regarding reinstatement rules.

9.7 Health FSA COBRA Continuation Coverage.

Section 7.2, *COBRA Continuation Coverage*, above describes in detail your COBRA rights. COBRA does apply under limited circumstances to the Health FSA, if the maximum amount available under the Health FSA for the remainder of the Plan Year is more than the maximum amount the Health FSA may charge you to maintain continued coverage under the Health FSA.

If you participate in the Health FSA and your employment is terminated or you (or your spouse or dependent child) experience another qualifying event under COBRA (e.g. reduced hours in your employment, divorce, death, loss of dependent status, entitlement to Medicare, etc.), you (or your spouse or dependent-child) may choose to continue coverage under such Health FSA for the remainder of that Plan Year only. In most cases, this means you would continue to contribute to your Health FSA not by salary reductions, but by after-tax payments. The after-tax cost for COBRA continuation of coverage would be 102% of the level of coverage in effect prior to COBRA. If you elect COBRA coverage, you could continue to be reimbursed for eligible health care expenses from your Health FSA for the remainder of that Plan Year. The advantage of electing COBRA coverage under the Health FSA is your ability to be reimbursed out of your account for eligible health care expenses incurred after the date of your termination or other qualifying event. For example, if you had unused credits in your account at the time of your termination, unless you elect COBRA coverage, these amounts can only be used to reimburse eligible health care expenses incurred before

your termination of employment. If you do not have any eligible health care expenses at that time, any unused credits will be forfeited. To avoid a forfeiture of unused credits, you could elect COBRA coverage and thereby continue to pay the premiums (e.g. 102% of your monthly payments on an after-tax basis) and be reimbursed for eligible health care expenses incurred after your employment termination date for the remainder of the Plan Year under the Health FSA. However, if you do not have any unused credits, you would no longer have a tax advantage to participating in the Health FSA and continuation coverage may not be an attractive option for you.

For Example: If you elected to contribute $1,000 to your account, and as of June 30, your date of termination, you had submitted claims for only $400, you would have an account balance of $600 ($1000 less $400). Your total COBRA premiums for the remainder of the year would be $510 ($85 per month x 6 months; the $85 payment is 102% of your monthly payment of $83.33). If your account balance is greater than the COBRA premiums for the remainder of the year, you will be offered the Health FSA under COBRA. If you elected COBRA coverage and made the COBRA premium payment of $85 per month on an after-tax basis, you could then receive reimbursement for qualified health care expenses rendered during the period of July – December 31 not to exceed the remaining balance of $600. If you do not elect COBRA, any unused account balance will be forfeited. If your account is instead negative at the time you terminated employment (i.e. the total COBRA premiums for the remainder of the Plan Year would exceed the balance in your account), then you are not eligible for COBRA with respect to the Health FSA.

When a qualifying event occurs, the Plan Administrator will provide you with more information regarding your COBRA rights, if any, including election requirements and procedures, duration of COBRA coverage and Premium Payment requirements. **Please note:** in the event of a divorce, legal separation or a child's losing dependent status, you or a family member must notify the Plan Administrator within 60 days of such event. Failure to do so will forfeit your and your spouse's or dependent's COBRA rights, if any. Please see Section 7.2, *COBRA Continuation Coverage*, above for more information on your COBRA rights and obligations.

9.8 Flexible Spending Accounts.

9.8.1 Eligibility for Spending Accounts. You are eligible to participate in the Health Care and Dependent Care FSAs if you are an Eligible Employee; provided you timely enroll in the manner described in Section 4.6, *Enrollment Process*, above. Your timely election for deferrals under the Health Care and/or Dependent Care FSA will become effective as of the payroll date coincident with or next following your Effective Date of Coverage. If you are reemployed as or change employment status to an Eligible Employee with the Employer, the rules set forth in Section 4.7, *Reenollment or Employment Status Change*, above shall govern when you become eligible for benefits under the Flexible Spending Account Plans.

9.8.2 General Description of Flexible Spending Account Plans. If you expect to have any uninsured medical, dental, vision, prescription or other health care expenses next year, or if you pay someone for the care of a child or an incapacitated dependent adult in order for you and your spouse to work, then you may be interested in the Spending Account Plans. You may establish two separate Spending Accounts – one for health care expenses and another for dependent care expenses. You may contribute to one of them, both of them or neither.

If you wish to participate in one or both, you do this by electing to defer a portion of your before-tax pay through payroll deduction. Each Spending Account is similar to a checking account. The Claims Administrator will make regular credits to your Spending Accounts for each pay period according to your election. When you incur a qualifying expense, you submit the receipt for reimbursement to the Claims Administrator with your reimbursement request. Money is then debited from your Spending Account to cover the expense and you receive the reimbursement. Money from your Health FSA can only be used for health care expenses. Money from your Dependent Care FSA can only be used for dependent care expenses. Money cannot be cross applied from one type of Spending Account to the other. **Any unused money in your account for a Plan Year generally will be forfeited**. Unused amounts will be retained by the Employer (to the extent permitted by law) or applied to reduce the administrative fee of the program. In order to maximize the tax advantage offered through the Spending Account program, you should carefully estimate your health and dependent care expenses before the beginning of each Plan Year.

You may elect the amount to be deferred from your pay and to be contributed to your account(s) during the Open Enrollment Period, as described earlier. The minimum and maximum amount that you may elect to contribute to each account each Plan Year is described below. Please note that the Plan Administrator automatically may decrease your elected amounts as required to pass certain nondiscrimination requirements under the Code.

9.9 Health Care Flexible Spending Account.

9.9.1 General Purpose Health Care Flexible Spending Account ("General Purpose FSA"). As an Eligible Employee, you may enroll in the General Purpose FSA if you are NOT enrolled in the HDHP-HSA option offered under this Plan as of the first day of the Plan Year for you (i.e., January 1 if you are an existing Eligible Employee or the date you first become eligible following your hire date).

> Note: if you want to be considered an Eligible Individual under another HDHP-HSA option maintained by any other entity, you should not enroll in the General Purpose FSA under this Plan for that same plan year, because coverage under this General Purpose FSA is considered coverage under a non-HDHP for you and any Enrolled Eligible Family Members, which would result in you and your Eligible Family Members not being considered Eligible Individuals for purposes or making or receiving contributions to a HSA.

You can be reimbursed from your General Purpose FSA for eligible health care expenses incurred by you, your Spouse and any Child who qualifies as your tax-dependents. Eligible health care expenses are the types of out-of-pocket health care expenses that are not paid for by your health insurance and that are generally considered eligible medical deductions on your federal income tax return under Code Section 213. Common examples include:

(A) Deductibles, co-payments or co-insurance under the Health Plans

(B) Eye exams, eyeglasses, contact lenses

(C) Prescription drugs or insulin not otherwise covered by insurance

(D) OTC drugs, including menstrual cycle products

(E) Hearing aids, false teeth, braces, orthopedic shoes, crutches, wheelchairs

(F) Ambulance service and other travel costs to get health care

However, the following expenses do **not** qualify as eligible health care expenses for reimbursement from your General Purpose FSA:

(A) Amounts reimbursed by other sources

(B) Cosmetic surgery

(C) Most weight loss program

(D) Health club dues

(E) Maternity clothes

(F) Electrolysis

(G) Premiums you pay for other health care coverage, including premiums for plans of your Spouse's employer

(H) Illegal operation or medical treatment

(I) Vitamins and other items designed to maintain general health (rather than to treat an illness)

IRS Publication 502, Medical and Dental Expenses, has a checklist of health care expenses that can be deducted on your tax return, and, thus may be reimbursable under the General Purpose FSA. Please contact the Plan Administrator if you have specific questions regarding which expenses can or cannot be reimbursed.

9.9.2 Special Coordination Rules Regarding General Purpose Health FSA and HSAs.

(A) Your election to enroll in the General Purpose is in effect for the entire Plan Year from January 1 through December 31, regardless of your account balance as of a particular day in the Plan Year; provided, however, your participation in the FSA may be terminated during a Plan Year pursuant to terms of this Plan document (e.g., upon your termination of employment). This may impact your mid-year decision to enroll in a HDHP-HSA option.

Example: Assume you elect to contribute $2,000 to a General Purpose FSA for the 2023 Plan Year, and you are covered under your spouse's non-HDHP, so you do not enroll in any of the Employer's medical option during 2023 Open Enrollment Period. Assume further you lose coverage under your Spouse's non-HDHP on June 30, 2023 and timely enroll in the Employer's HDHP-HSA option effective July 1, 2023.

Although you may receive coverage under the Employer's HDHP, you are not an Eligible Individual for purposes of making or receiving HSA contributions because you are still covered under the General Purpose FSA for the entire 2023 Plan Year. This is the case even if you have fully used and been reimbursed for $2,000 of eligible health care expenses from your General Purpose FSA prior to July 1, 2023. **You will not be eligible for the Employer HSA contribution, if any.**

If you make or receive contributions to an HSA when you are not an Eligible Individual, you should contact the HSA custodian to request that any excess contributions be returned to you and you will be required to include such excess contributions in your taxable income (if those amounts were made with pre-tax dollars or employer contributions). If an excess contribution remains in your HSA beyond April 15th following the year in which the excess contribution was made to your HSA, you will be subject to a six percent (6%) excise tax on such excess contributions.

It is your sole responsibility to determine if you are an Eligible Individual for purposes of making or receiving HSA contributions and for any tax liability with respect to your HSA. You should consult with your tax professional for more information. The Plan Administrator has an HSA FAQ as a resource available to you as well.

(B) Having an unspent account balance in your General Purpose Health Care Spending Account as of the last day of the Plan Year (December 31) could delay the effective date of when you would be considered an Eligible Individual for purposes of making or receiving contributions to a HSA for the new Plan Year. For this reason, you are strongly recommended to fully spend down and zero out your account balance in your General Purpose Health Care Spending Account before the last day of the Plan (December 31), if you intend to enroll in the Employer's HDHP-HSA for the next Plan Year. Specifically, this coordination issue arises out of the Grace Period feature available to your General Purpose Health Care Spending Account, which allows you to incur and be reimbursed for general-purpose health care expenses until March 15 following the Plan Year in which there was an unused account balance as of December 31 in your General Purpose Health Care Spending Account. As a result, the IRS will not consider you to be an Eligible Individual due to being covered under a non-HDHP (i.e. the General Purpose Health Care Spending Account) for purposes of making or receiving contributions to your HSA until the first day of the month following the close of the Grace Period (i.e. you will not become an Eligible Individual until April 1). In other words, you will not be eligible to legally set up your HSA and start making or receiving contributions to it until April 1, which partial year as an Eligible Individual could impact the maximum annual contributions under your HSA for the calendar year. Please contact the Plan Administrator for more information regarding this coordination issue between the General Purpose Health Care Spending Account with a Grace Period and the HDHP-HSA option.

9.9.3 Amount of Health FSA Annual Contribution. You must decide the amount, if any, to contribute to your Health Care Spending Account for each Plan Year during the Open Enrollment Period. You should review carefully your (and your Eligible Family Member's) health care expenses from prior years to estimate predictable expenses for the upcoming Plan Year. You can elect to contribute each Plan Year the minimum and maximum amounts as determined by the Plan Administrator each Plan Year, which amounts will be communicated to you during the Annual or other Enrollment Periods. Please note that the Employer may, to the extent permitted or required by law, increase or decrease the minimum and maximum amounts at any time without a formal plan amendment–you will be notified of any such change during your enrollment period.

9.9.4 Reimbursement of Health FSA Claims. The full amount that you elect to contribute to your Health FSA for a Plan Year will be available to you for reimbursement at the beginning of the Plan Year, regardless of the amount of money in your account at the time you request a reimbursement.

You may submit a claim when you have incurred an eligible health care expenses. Claims are processed and typically paid on a monthly basis. Your claim request must be sent to the Claims Administrator in the manner established by such Claims Administrator (as indicated in Appendix B).

Claims requests must be accompanied by original bills, invoices, receipts or other statements showing the amounts of such expenses, together with any additional documentation which the Claims Administrator may request. The Plan Administrator (or its Claims Administrator), in its sole discretion, may provide Participants with a Flex Debit Card to be used for reimbursement of eligible health care expenses (in lieu of a Participant submitting a claim request for reimbursement). The terms of any such Flex Debit Card program will be established by the Plan Administrator and communicated to Participants. The Plan Administrator, if it deems necessary, may require that you submit additional information for the Plan Administrator's consideration of your request for reimbursement or for the Plan Administrator to substantiate charges on a Flex Debit Card. Properly submitted claims will be reimbursed, on such date as designated by the Plan Administrator.

You may submit claims to the Plan Administrator for reimbursement only for those health care expenses that are incurred while you are a Participant in the Health FSA and that are incurred on or before the last day of the Plan Year (or its Grace Period).

You have until the earlier of 90 days immediately following the end of the Plan Year or 90 days from the date your participation in the Health FSA ends to submit claims for incurred health care expenses that you incurred in the prior Plan Year, unless a different date is set forth in the Supplemental Plan Document.

9.9.5 Forfeiture of Unused Health FSA Contributions. The law generally requires that you use all of the money in your Health FSA by the end of the Plan Year. However, the Health FSA grants you a Grace Period, as long as you do not elect to participate in the Employer's HDHP-HSA option for the new Plan Year. If you enroll in the Employer's HDHP-HSA option for the new Plan Year, you are not eligible for the Grace Period feature.

> Example: Assume you have $300 remaining in your General Purpose Health FSA as of December 31, 2023, and you enroll in the Employer's HDHP-HSA for the Plan Year beginning on January 1, 2024. You will not be eligible for the Grace Period feature; meaning that you will be given additional time through March 15, 2024 to incur eligible health expenses to spenddown any unused dollars. As a result, if you plan to enroll in the Employer's HDHP-HSA for a new Plan Year, you should make sure you incur enough eligible health expenses on and before December 31 to avoid any forfeitures. Remember, OTC drugs and menstrual cycle products are now considered eligible health expenses which can reimbursed from your General Purpose Health FSA (as well as from any HSA).

If you are eligible for the Grace Period feature, it will end on the March 15th following the close of each the Plan Year, during which period you may incur additional eligible health expenses to spend down your unused money to avoid a forfeiture. Unused dollars in your account after the Grace Period ends will be forfeited. Therefore, you should carefully account for the health care expenses you expect to incur for each Plan Year before making your annual elections. Any unused amount of coverage elected by you for a Plan Year resulting from your failure to timely submit proper claims for reimbursement by the submission deadline will be forfeited in the same manner. Any amount that you forfeit will be retained by the Employer, to the extent permitted by law, and/or applied toward Plan administrative expenses.

9.9.6 Reimbursements From the Health FSA After Termination of Participation. When you cease to be a Participant under the Health FSA, your pre-tax contributions and election to participate will terminate. You will not be able to receive reimbursements for health care expenses incurred after the end of the day on which your employment terminates or you otherwise cease to be eligible, unless you elect COBRA coverage as explained in Section 9.6 above. However, you (or your estate) may claim reimbursement for any health care expenses incurred during your period of coverage prior to the date that you cease to be eligible, provided that you (or your estate) files a claim within **90 days** after the date that you cease to be a Participant. Any unused account balance for a Plan Year resulting from your failure to timely submit proper claims for reimbursement by the submission deadline will be forfeited in the same manner. Any amount that you forfeit will be retained by the Employer, to the extent permitted by ERISA, or applied toward administration expenses under the Health FSA.

9.9.7 FMLA Leave, Employer-Approved Leave or USERRA Leave. If you are absent from work, you have the rights described under Section 6.2, *Continuation of Coverage during Layoff or Certain Leave of Absence,* above with respect to your coverage under the Health FSA during such a Leave.

If your coverage under the Health FSA is suspended during a FMLA leave and you return to work from within the same Plan Year your leave began, you may: (i) resume coverage under the Health FSA at the level in effect before your leave plus make-up the unpaid contribution payments for your leave period, or (ii) resume coverage under the Health FSA at the level in effect before your leave only (i.e. a reduced level of contributions that is prorated for the period of leave for which no contributions were paid). In both of these cases, the level of your contribution to the Health FSA is reduced by any prior reimbursements made to you. Regardless of your choice, you are not entitled to reimbursement for claims incurred during the period when your coverage was terminated or suspended under the Health FSA.

If you return from such a leave in a Plan Year subsequent to the year the FMLA leave commenced, you will be required to complete the new enrollment process under the Cafeteria Plan in the manner and by the deadline established by the Plan Administrator (or its Claims Administrator), if you want to participate in the Health FSA; participation will commence as of the date established by the Plan Administrator in accordance with the provisions of this Plan document and the Cafeteria Plan.

9.9.8 Eligible Family Members' Reimbursement and Qualified Medical Child Support Orders. The Health FSA may reimburse you for the health care expenses incurred by your Eligible Family Members who are your legal Spouse or Child who meets the Code Section 152 definition of "dependent" (without regard to the earnings limit under §152(d)(1)(B), the special exclusions under §152(b)(1) or (2), or the age or student status requirements under §152(c)(3), provided that such dependent is age 26 or under during the entire Plan Year). An Eligible Family Member also will include any individual to whom you are required to provide health benefit coverage under a Qualified Medical Child Support Order. The Plan Administrator has established written procedures governing Qualified Medical Child Support Orders. You may obtain a copy, without charge, of such procedures from the Plan Administrator.

9.9.9 Coordination of Benefits. Health FSA Your Health FSA is intended to reimburse you solely for health care expenses for which you have not been previously reimbursed and will not seek reimbursement elsewhere. If an Eligible Family Member has established a health FSA at their employer, that health FSA should pay for the Eligible Family Member's health care expenses before they are submitted to this Plan for reimbursement. However, the Health FSA is not subject to the coordination of benefits rules set forth in Section 14 below, and Health FSA reimbursements under this Plan shall not be taken into account when determining benefits payable under any other plan.

9.10 Dependent Care Flexible Spending Account.

You can be reimbursed for work-related dependent care expenses from your Dependent Care FSA established under the Dependent Care FSA Plan. If you are married, you can use the account if you and your Spouse are both gainfully employed (as defined under IRS guidance), or if your Spouse is a full-time student (in some cases). Single employees also can use the account for dependent care expenses if they are gainfully employed.

9.10.1 Eligible Family Members. You can be reimbursed for expenses for the care of a qualifying individual (as defined by Code Section 21(b)(1)). A qualifying individual includes:

(A) your tax dependent who is a qualifying child within the meaning of Code Section 152 and who has not attained age 13; or

(B) your dependent (as defined under Code Section 152, without regard to 152(b)(1) and (2) or 152(d)(1)(B)) or your Spouse, if such dependent or Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the Plan Year.

However, in the case of divorced or separated parents, a qualifying individual who is a child shall be treated as ta qualifying individual of the custodial parent and not the non-custodial parent.

9.10.2 Eligible Care. You can be reimbursed for "eligible dependent care costs." The types of dependent care costs that are permitted to be reimbursed include:

(A) Care in your home;

(B) Care in someone else's home;

(C) Care in a dependent care center that cares for 6 or more individuals (other than individuals who reside at the facility) and is licensed under state and local laws;

(D) Care in an educational institution for pre-schoolers (if the primary purpose of the preschool is to care for the child);

(E) Care for an incapacitated dependent either inside or outside of your home, but the dependent must spend at least eight hours in your home if you are claiming reimbursement for care outside your home.

(F) Care by a relative who is not a dependent.

The types of dependent care costs that are **not** reimbursable include:

(G) Payments to a care provider who is your dependent;

(H) Payments to your child who is under 19;

(I) Payments for non-work related care;

(J) Payments for overnight camp, field trips or transportation;

(K) Expenses for which the federal child care income tax credit is taken;

(L) Medical, dental or nursing home expenses;

(M) Education in kindergarten or higher grade;

(N) Payments for an eligible dependent's food, clothing, diaper changing, late fees, education, or entertainment.

9.10.3 Amount of Dependent Care FSA Annual Contributions. You must decide the amount, if any, to contribute to your Dependent Care FSA for each Plan Year during the Open Enrollment Period. You should review carefully your dependent care expenses from prior years to estimate predictable expenses for the upcoming Plan Year. The amount that you elect for a Plan Year will be withheld (before-tax) from your pay on a pro-rata basis over the course of the year. The maximum amount that you may contribute to your account for a Plan Year is set by law and may not exceed the lesser of:

(A) $5,000 ($2,500 if a separate income tax return is filed by you and you are married); or

(B) Your Earned Income for the Plan Year or, if married, the actual or deemed Earned Income of your Spouse for the Plan Year if less than your Earned Income. Earned Income means all of your income derived from wages, salaries, tips, self-employment, and other compensation, but excluding amounts withheld from your pay under the Cafeteria Plan for dependent care expenses. In the case of your spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have Earned Income of not less than $200 per month if you have 1 dependent and $400 per month if you have 2 or more dependents.

This maximum amount may be automatically increased under the Dependent Care FSA Plan if the Plan Administrator elects to apply an increase that is permitted under Code Section 129. The minimum annual amount, if any, which you may elect to defer to your Account is set forth in Appendix B.

9.10.4 Federal Tax Credit. Your federal income taxes are permitted to be reduced by a percentage of your dependent care expenses. This is called a federal tax credit. The percentage amount depends on your income level. The total amount of dependent care expenses eligible for the federal tax credit is $3,000 for one child and $6,000 for two or more children.

You are not permitted to take the federal tax credit and use your Dependent Care FSA for the same expense. The federal tax credit will be reduced dollar for dollar by any expenses reimbursed through your Dependent Care FSA.

In some cases, you will save more on taxes if you take the federal tax credit than if you pay for dependent care through the Cafeteria Plan. You should consult a qualified tax advisor for assistance in deciding which is better for you.

9.10.5 Reimbursement of Dependent Care FSA Claims. You only may be reimbursed for dependent care expenses up to the amount that actually is in your Dependent Care FSA. For example, if you contribute $100 per paycheck to the Dependent Care FSA, and are paid twice a month, then you only can be reimbursed for $200 of expenses at the end of the first month of the Plan Year, even if your dependent care expenses are $250 at that time.

You may periodically submit a claim for reimbursement as you incur dependent care expenses and those claims are processed in the manner established and timeframe established by the Claims Administrator identified in Appendix B. Your claims must be accompanied by original bills, invoices, receipts or other statements showing the amounts of such expenses, together with any additional documentation that the Claims Administrator may request. You also must provide the name, address and taxpayer identification number or social security number of your dependent care provider (day care center, babysitter, relative) on your federal tax return to take advantage of the Dependent Care FSA.

You may submit claims to the Plan Administrator for reimbursement only for those Dependent Care Expenses that are incurred after you became a Participant in the Dependent Care FSA Plan and that are incurred on or before the last day of the Plan Year (December 31st) or its Grace Period, or, if earlier, the date your participation in the Dependent Care FSA ends.

You have until the earlier of 90 days immediately following the end of the Plan Year or 90 days from the date your participation in the Dependent Care FSA ends to submit claims for incurred dependent care expenses, unless a different date is set forth in the Supplemental Plan Document.

9.10.6 Forfeiture of Unused Amounts. You generally must use all of the money in your Dependent Care FSA by the earlier of the last day of the Plan Year or the date on which your participation terminates. However, the Dependent Care FSA grants you a Grace Period during which you may incur additional eligible dependent expenses to spend down your unused money to avoid a forfeiture. The Grace Period ends on the March 15th following the close of each the Plan Year. Unused dollars in your account after the Grace Period ends will be forfeited. Any unused amount of coverage elected by you for a Plan Year resulting from your failure to timely submit proper claims for reimbursement by the submission deadline will be forfeited in the same manner. Any amount that you forfeit will be retained by the Employer, to the extent permitted by law, and/or applied toward Plan administrative expenses.

9.10.7 Participation under the Dependent Care FSA Plan During a Leave. If you are absent from work due to any leave of absence (whether or not you receive pay during such leave), your coverage under the Dependent Care Flexible Spending Account Plan automatically will be suspended during that leave period. Alternatively, you may elect to revoke your coverage under the Dependent Care FSA Plan for the remainder of the Plan Year. In no event are you entitled to (i) reimbursement for claims incurred during the leave period when your coverage was revoked or suspended under the Dependent Care FSA Plan, nor (ii) greater benefits upon restoration for the remainder of the Plan Year relative to contributions paid by an Employee who is continuously employed during the Plan Year. If you return from a leave in a Plan Year subsequent to the year the leave commenced, you will be required to complete the new election process under the Cafeteria Plan by the deadline and in the manner established by the Plan Administrator (or its Claims Administrator), if you want to resume participation in the Dependent Care FSA Plan. Participation in the Dependent Care FSA Plan will commence as of the Effective Date of Coverage following timely completion of the enrollment process.

9.10.8 Reports. On or before January 31 of each year, the Plan Administrator will provide you with a written statement showing the amounts paid or expenses incurred under your Dependent Care FSAs during the previous calendar year.

9.11 Health Savings Account Contributions.

If you are enrolled in the Employer's HDHP-HSA option and you determine that you are an "Eligible Individual," you may elect to make pre-tax employee contributions to Health Savings Account. You are an Eligible Individual if you are covered under a High Deductible Health Plan and are otherwise eligible to establish and make contributions to a Health Savings Account pursuant to Code Section 223 and related IRS regulations and guidance (see Section 18, *Definitions*, for more information on these requirements). However, you are only permitted to make pre-tax contributions through the Employer's Cafeteria Plan to a health savings account that is linked to the Employer's High Deductible Plan and provided through the trustee or custodian chosen by the Employer.

Any pre-tax employee contributions to your HSA under the Cafeteria Plan shall relate to your taxable year during which such contributions are deducted from your compensation (regardless of your ability to make such contributions for a given taxable year at any time prior to the time prescribed by (without extensions) for filing your federal income tax return for that year).

In the sole discretion of the Employer, an employer contribution may be made to your HSA, which also shall be made through the Cafeteria Plan. The amount, timing and other terms of such employer contribution to the HSA generally shall be governed by policies and procedures established in the sole discretion of the Plan Administrator; notwithstanding anything to the contrary, however, the following rules shall apply:

(A) Employer contributions shall be made only to the HSA that is linked to the HDHP option offered under the Medical Plan.

(B) In the discretion of the Plan Administrator, the total amount of employer contributions to your HSA may be prorated for a partial year of employment or status as an Eligible Individual.

(C) Employer contributions to your HSA shall be made only in the event you have timely and properly established the HSA in accordance with the requirements of the trustee or custodian (including completion of the paperwork to include your name, social security number, date of birth, and residential street address, etc.) prior to the date on which the Employer transfers the employer contribution to its Claims Administrator for allocation to the HSA (the "fund date"). If you fail to timely and properly establish the HSA by the fund date, the Plan Administrator, in its sole discretion, may deem you ineligible to receive the employer contribution attributable to such fund date.

(D) Employer contributions to your HSA shall cease on the earlier of the date you are no longer covered under the HDHP option under the Medical Plan or no longer receiving a paycheck from the Employer.

Your election to make pre-tax employee contribution to your HSA through the Cafeteria Plan also will cease as of the earliest of the date on which you change your pre-tax contribution election; you are no longer eligible for participation in the Employer's HDHP-HSA option; or you are no longer receiving a paycheck from the Employer.

While the high deductible health plan portion of the Employer's HDHP option is an ERISA-governed plan sponsored by the Employer, any HSA linked to the HDHP option or independently established by you or your Eligible Family Member is not sponsored or maintained by the Employer and is not subject to or governed by ERISA. You are the owner of such HSA and solely responsible for (i) determining if you are an Eligible Individual who can establish, and make or receive contributions to an HSA, (ii) determining the amount of contributions that may be made or received under your HSA each taxable year, (iii) requesting distributions and determining if they are qualifying or non-qualifying expenses under the HSA; and (iv) all tax consequences arising under or connection with your HSA.

The Employer also has prepared "Frequently Asked Questions About the HDHP-HSA Option." Please review this FAQ carefully to fully understand how the HSA works and your tax considerations.

9.12 Tax Savings.

The Cafeteria Plan allows you to contribute "before-tax" dollars to purchase your healthcare benefits under the Health Plans and also set aside pre-tax dollars to your Spending Accounts to be used to reimburse you for eligible health and dependent care expenses. By paying with "before-tax" dollars, you will reduce the amount of income and social security taxes that you otherwise would be required to pay. The below example demonstrates these tax savings.

Example – Jack and his wife Janet combined earn $50,000 per year. Under Jack's old health care plan, he was required to pay his premiums with "after-tax" dollars and there was no Spending Accounts. Under Jack's new cafeteria plan,

he will be permitted to pay his premiums with "before-tax" dollars and to set aside pre-tax dollars for reimbursement of other eligible health and dependent care expenses. Jack's employer requires that Jack contribute $200 per month towards the cost of his coverage under the medical and dental care plan and Jack and Janet expect to spend $2,500 for after school child care and $1,000 in uninsured health care expenses.

	Old Plan Without Cafeteria Plan	Cafeteria Plan
Gross Income	$50,000	$50,000
Jack's Annual Premiums on a Before-tax Basis	-0-	(5,900)
Adjusted Gross Income	$50,000	$44,100
Estimated Federal and State Income and FICA (Social Security and Medicare) Taxes (estimated at a 27% of pay tax rate)	(13,500)	(11,907)
Jack's Annual Premiums and Health and Dependent Care Expenses on an After-tax Basis	(5,900)	-0-
Disposable Income	$30,600	$32,193

Jack and Janet's annual savings under the cafeteria plan will be $1,593 per year ($32,193 - $30,600).

9.13 Social Security Taxes.

Social Security taxes are not deducted from the amount you contribute to the Cafeteria Plan on a before tax basis. Your take-home pay is larger because you save on taxes, including "FICA" taxes, but your future Social Security benefits may be less at retirement because of this. In most cases, however, the reduction in Social Security benefits is minimal, and the tax advantages you otherwise gain through contributing to the Cafeteria Plan offset any possible reduction in Social Security benefits.

10. OTHER WELFARE BENEFITS

10.1 Employee Assistance Program (EAP)

10.1.1 Purpose of the EAP. The Employer cares about the health and well-being of its employees and recognizes that a variety of personal problems can disrupt their personal and work lives. While many employees are able to resolve problems either on their own, or with the help of family and friends, sometimes employees need professional assistance and advice. The EAP offers help to Employees, their spouses, and dependents with the resolution of problems that may be affecting work or their personal lives; the EAP is designed as a referral source to assist you and your family members find resources to help overcome personal problems. These problems do not have to be caused workplace issues. Eligible Employees may be referred to the EAP by the Employer or may seek assistance voluntarily. In either event, participation in the EAP is strictly voluntary and confidential, even from the Employer.

10.1.2 Eligibility Requirements. Except as otherwise provided in the applicable Supplemental Plan Document, all Eligible Employees of the Employer, their Eligible Family Members, are eligible to participate in the Employee Assistance Program as of the Effective Date of Coverage.

10.1.3 Benefits. The Employer has contracted with the Claims Administrator identified in Appendix B to provide the services offered under the EAP. The EAP services include referral services for personal, financial, legal, emotional, behavioral, mental health, alcohol and other substance use disorders, and similar concerns of household members. The EAP is not designed to provide significant health care benefits, therapy or intensive treatment. The Claims Administrator will provide services to Eligible Employees and household members in accordance with its Supplemental Plan Document, a copy of which is available from the Employer.

10.1.4 Cost of Participation. There is no charge to Eligible Employees and their Eligible Family Members for services under the EAP. However, any costs for therapy or other services recommended under these programs will be subject to current health plan coverage or be the responsibility of the Eligible Employee.

10.1.5 Confidentiality. The counseling of Eligible Employee and Eligible Family Members through these programs is held in strict confidence. The Plan Administrator will not have access to any identifying data or information concerning who has used or is involved with receiving these services under the programs, without

written permission of the individual. In addition, involvement in the EAP will not be a factor for consideration in the Eligible Employee's performance evaluation.

10.1.6 Termination of Coverage. Your participation under the EAP will end upon the occurrence of any of the events set forth in Section 6 above. The Employer has adopted a Severance Policy as described in the Supplemental Plan Documents. You are eligible for severance benefits only if you satisfy the eligibility conditions set forth in the Supplemental Plan Documents, which are incorporated by reference herein, and indicated as provided to your Employee Group in the applicable Appendix B.

10.2 Severance Plan

The Employer has adopted a Severance Plan as described in the Supplemental Plan Documents. You are eligible for severance benefits only if you satisfy the eligibility conditions set forth in the Supplemental Plan Documents, which are incorporated by reference herein, and indicated as provided to your Employee Group in the applicable Appendix B.

11. ADMINISTRATION/AMENDMENT, MODIFICATION AND TERMINATION OF THE PLAN

11.1 Powers and Authority of the Plan Administrator.

The Plan Administrator will have any and all power and authority which will be necessary, advisable, desirable, or convenient to enable it to carry out its duties under the Plan, including by way of illustration and not limitation, the powers and authority to:

(A) Make the final decisions about applications for or entitlement to Plan benefits, including:

(1) The computation of the amount of benefits which will be payable in accordance with the terms of the Plan;

(2) The right to obtain additional information needed to coordinate benefit payments with other plans; and

(3) The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law.

(B) Interpret in good faith all Plan provisions and associated administrative rules and procedures, and correct any defect, supply any omissions, or reconcile any inconsistencies, such interpretation will be final, conclusive, and binding on all persons claiming benefits under the Plan.

(C) Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

(D) Make rules and regulations with respect to the Plan not inconsistent with the Plan, the Code, or ERISA that the Plan Administrator deems necessary or proper for the efficient administration of the Plan.

(E) Determine, consistent with the Plan, the Code, and ERISA, all questions that may arise as to the eligibility, benefits, status and right of any person claiming benefits under the Plan, including (without limitation) Participants, former Participants, and surviving spouses of Participants.

(F) Appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan.

(G) Allocate and delegate the responsibilities of the Plan Administrator under the Plan and designate other persons or committees to carry out any of such responsibilities, any such allocation, delegation or designation to be in writing. Any employees who are delegated any such responsibility will be acting as agents of the Employer and not in their individual capacities.

The Plan gives the Plan Administrator, or any person or entity to whom the Plan Administrator has delegated any of its duties in writing, full discretion and sole authority to make the final decision in all areas of plan interpretation and

administration, including eligibility for benefits, the level of benefit provided, and the meaning of all Plan language. The decision of the Plan Administrator or its delegate is final and binding on all those dealing with the Plan and if challenged in court, the Plan intends for the Plan Administrator's or its delegate's decision to be upheld unless it is deemed to be arbitrary and capricious.

Refer to Section 18 for information on Claims Administrators and the Supplemental Plan Documents to which the Plan Administrator has delegated certain authority with respect to claims and appeals.

11.2 Right to Amend, Modify or Terminate the Plan.

The benefits described in this Plan are not vested benefits, and the Employer reserves the right, in its sole discretion, to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason, without prior notification. This right includes the authority to amend, modify or terminate any of the benefit options available under the Plan, the Premium Payment and other cost-sharing requirements under the Plan or make any other modification.

11.3 Indemnification.

No director, officer or employee of the Employer will be liable for any action or failure to act under or in connection with the Plan; provided, however, that nothing herein will be deemed to relieve any such person from responsibility or liability for any obligation or duty otherwise imposed under ERISA. Each director, officer, or employee of the Employer who is or will have been designated to act on behalf of the Employer will be indemnified and held harmless by the Employer against and from any and all loss, cost, liability or expense that may be imposed upon or reasonably incurred by him or her in connection with or resulting from any claim, action, suit or proceeding to which he or she may be a party or in which he or she may be involved by reason of any legal action taken or failure to act under or in connection with the Plan and against and from any and all amounts paid by him or her in settlement thereof (with the Employer's written approval) or paid by him or her in condition that, upon a finding of his or her lack of good faith; subject, however, to the condition that, upon the assertion or institution of any such claim, action, suit or proceeding against him or her, he or she will in writing give the Employer an opportunity, at its own expense, to handle and defend the same before he or she undertakes to handle and defend it on his or her own behalf. The foregoing right of indemnification will not be exclusive of any other right to which such person may be entitled as a matter of law or otherwise.

11.4 Drafting Ambiguities.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Employer in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan fiduciaries in the fashion consistent with its intent, as determined by the Employer in its sole discretion. The Employer will amend the Plan (retroactively if necessary) to cure any such ambiguities. This Section may not be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by Plan fiduciaries.

12. COORDINATION OF BENEFITS

12.1 Non-Duplication of Benefits.

There is no duplication of benefits under this Plan.

12.2 Coordination of Benefits.

Coordination of Benefits ("COB") means that if you, your Spouse or Children are covered under this Plan and one or more Other Benefit Plans, the plans will coordinate benefit payments. When this Plan is primary under the provisions of this Section, it will pay its full benefits, just as if you had no Other Benefit Plan coverage. When this Plan is secondary under the provisions of this Section, it will not pay until after the Other Benefit Plans have paid its benefits as primary coverage. The Plan will then pay the allowable charges or expenses left unpaid by the Other Benefit Plans to the extent such amounts would have been paid by this Plan if it had been primary. In other words, this Plan, as secondary coverage, will pay the amount it would have otherwise paid, minus whatever the primary plan is responsible for paying, so that benefits are not duplicated. Benefits payable under the Other Benefit Plans are considered, regardless of whether a claim has been filed. The combined payments from all plans may not exceed 100% of expenses

incurred. The total payments from this Plan will never be more than the amount that would have been paid if this Plan had been the primary plan.

12.3 Other Benefit Plan.

This Plan coordinates benefits under the Health Plans with the following types of "Other Benefit Plan":

(A) Group plans (insured or self-insured) or group-type plans including but not limited to franchise or blanket benefit plans, Blue Cross and Blue Shield group plans, and group practice and other group prepayment plans.

(B) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(C) Other plans required or provided by law.

(D) Any automobile insurance policies (including "at-fault" and "no-fault" coverage) containing personal injury protections.

12.4 Allowable Amount or Charge.

For a charge to be considered or paid, at least part of it must be covered under this Plan or the applicable Supplemental Plan Document. Only the allowed amount of the charge will be considered or paid as defined in the Supplemental Plan Documents.

In the case of a Health Maintenance Organization ("HMO") or other in-network only plan, this paragraph will apply. This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. When an HMO or network plan is primary, and the Participant does not use an HMO or network provider, this Plan will not consider as an allowed amount any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

The Plan will not pay, as secondary coverage, an amount that the Other Benefit Plan, as primary coverage, did not pay because you did not follow its rules and procedures. For example, if the Other Benefit Plan has reduced its benefit because you did not obtain pre-certification, as required by the Other Benefit Plan, this Plan will not pay the amount of the reduction, because it is not an allowable amount or charge.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable amount.

12.5 How Coordination of Benefits Works.

Here are examples of how Coordination of Benefits works when you see a PPO Provider within your network:

	Example 1	Example 2
Total Allowed Charge	$200	$200
Amount applied to this Plan's Deductible	*$100	*$100
This Plan's Benefit Amount	**$80	**$80
Amount paid by other plan	$50	$80
Remaining amount this Plan will pay	$30	$0

*Satisfied remaining Deductible for the year

**80% of remaining $100 of the $200 allowable charge

12.6 Benefit Plan Payment Order.

The general order-of-payment rules among this Plan and Other Benefit Plans (collectively referred to as "the plan" under this Section) are as follows:

12.6.1 No COB Provision. The plan that does not contain COB provisions always pay before those plans that have COB provisions.

12.6.2 Employee vs Dependent. The plan that covers a person directly as an employee, member or subscriber always pays before the plans that cover that person as a dependent.

12.6.3 Active Status vs Inactive Status. The plan that covers a person as an active employee or as a spouse or dependent of an active employee pays before the plan that covers a person as an inactive employee or as a spouse or other dependent of an inactive employee (including, but not limited, inactive coverage related to a retired employee or laid-off employee).

12.6.4 Disability Extension. The plan that covers a person as an active member under a disability extension will pay before other plans.

12.6.5 Active Coverage vs COBRA. The plan that covers a person as an active employee or as a spouse or dependent of an active employee pays before the plans that cover the person as a COBRA beneficiary under federal COBRA law or any state or other law providing right to continue coverage under the plan.

12.6.6 Children of Married Couples. With respect to a plan that covers the children of parents who are married (and not legally separated or divorced) or who are living together (whether or not they have ever been married), the plan that covers the parent whose birthday (month and day of birth, not year) falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year.

> Example: John's birthdate is June 26, 1966. Mary's birthdate is December 16, 1965. John's birthdate falls earlier in the year, so John's plan would pay primary, and Mary's plan would pay secondary.

If both parents have the same birthday (month and day of the birth, but not year), the plan which has covered the parent for the longer time is primary and the plan which covers the other parent is secondary.

> Example: John's birthdate is April 17, 1955, and his plan coverage was effective January 1, 2007. Mary's birthdate is April 17, 1954, and her plan coverage was effective June 1, 2010. John's plan coverage was in effect longer than Mary's plan coverage. So, John's plan pays primary, and Mary's pays secondary.

12.6.7 Children of Non-married Couples. With respect to the plan that covers children whose parents were never married, are legally separated or divorced or are not living together:

(A) **QMCSO or Court Order**. The plan covering the parent whose financial responsibility for the child's health care expenses is established by a Qualified Medical Child Support Order (QMCSO), or by order of a court of competent jurisdiction, pays primary.

(B) **Birthday Rule**. the plan covering the natural parent whose birthday falls earliest in the year pays first if (i) a QMCSO or court decree provides that both parents are equally responsible for the child's health care, or (ii) a court decree does not state who is specifically responsible for the child's health care, and states the parents have joint physical custody.

(C) **Physical Custody Rule**. If the criteria above does not decide which plan pays primary, the order of payment is as follows:

(1) The plan of the parent with sole physical custody, then

(2) The plan of the stepparent who is married to the parent with sole physical custody, then

(3) The plan of the parent without physical custody, then

(4) The plan of the stepparent who is married to the parent without physical custody.

12.6.8 Auto Insurance. Except as otherwise provided in the Supplemental Plan Documents, if you or an Eligible Dependent are involved in a motor vehicle or cycle accident, payment for medical or other expenses will be coordinated between the applicable Health Plan and your auto or motorcycle insurance carrier with the auto insurance carrier paying as primary and the Health Plan paying as secondary. The Health Plan generally will reject auto or motorcycle accident related claims received until you submit proof of primary payment by the auto or motorcycle insurance policy. This Plan shall be considered the secondary carrier regardless of the individual's election under personal injury protection ("PIP") coverage with the auto carrier.

12.6.9 Situations Not Addressed in this Section. Any situations not addressed in this Plan document will be handled in accordance with the guidelines established for coordination of benefits by the National Association of Insurance Commissioners (e.g. if the rules in this Section 12 do not determine the order, the plan that has covered the individual for the longer period of time will be primary).

12.7 Special Rules for Coordination with Medicare.

Medicare will pay primary, secondary or last to the extent stated in federal law under the Medicare Secondary Payer ("MSP") rules. In the event of a conflict between the MSP rules and the terms of this Section, the MSP rules will apply.

12.7.1 Disability or Working-Age Medicare Coverage. If you (or your Eligible Family Members) are disabled or attain age 65 and become eligible for Medicare while you are still working for the Employer, regular coverage under the Health Plan shall automatically continue for you (or your Eligible Family Members) as the primary plan (and any elected Medicare coverage shall pay as secondary coverage. The only exception is when you decide (or your Eligible Family Member decides) to select Medicare as the primary and sole plan. If Medicare is selected as the primary and sole plan while you are still an active employee with the Employer, then coverage under this Plan will terminate; the Employer cannot provide you (or your Eligible Family Members) with any incentives to elect Medicare as primary and sole coverage. You should consult with your own advisor on whether or not to enroll in Medicare benefits when first eligible; Medicare may provide additional health care benefits to you, even as the secondary, but also will impact your status as an Eligible Employee to make or receive contributions to your HSA.

12.7.2 End Stage Renal Disease (ESRD) Medicare. If you (or your Eligible Family Members) become eligible for Medicare based solely on ESRD, the Plan will pay as primary for the Medicare 30-month coordination period beginning with the month in which you (or your Eligible Family Members) could have been enrolled had timely application for Medicare been made. Medicare shall become primary and this Plan will be secondary after the 30-month coordination period, as long as the individual retains eligibility based on ESRD (even if you or your Eligible Family Member also becomes eligible for Disability or Working Aged Medicare). If the ESRD-based eligibility ends, then the Disability or Working Aged Medicare rules apply as set forth above (i.e., the Plan will become primary with Medicare secondary when ESRD-based Medicare terminates and you are still working for the Employer with Disability or Working-Aged Medicare).

12.8 Medicaid or Any State Children's Health Insurance Program.

The fact that an Employee, Spouse or Child is eligible for medical assistance under a state plan for health assistance under the Social Security Act or a state Children's Health Insurance Program will not be taken into account in enrolling or making any payments for benefits with respect to the Employee, Spouse or Child.

In the event that you or your Eligible Family Members are enrolled in this Plan and also entitled to Medicaid or state children's health insurance benefits, this Plan shall pay primary. You may be able to submit any expenses not otherwise covered or allowable under this Plan to Medicaid or such other state program for reimbursement as secondary payer. It is your sole responsible to seek such other reimbursements and this Plan will not be involved with coordinating those benefits on your behalf.

12.9 Special Rule for Eligible Family Members in a Hospital on the Effective Date of Coverage.

If your Spouse or other Eligible Family Member is in a Hospital on the date that your enrollment in this Plan is effective, this Plan will be the secondary payer to any other plan covering such individual until the date that he or she is discharged from the Hospital.

12.10 Right to Receive or Release Necessary Information.

For the purpose of Coordination of Benefits, the Plan Administrator may release to, or obtain from, any other insurance company or other organization or individual any claim information or Benefit Plan information, and any individual claiming benefits under the Plan must furnish any information that the Plan Sponsor may require.

12.11 Facility of Payment.

The Plan may pay to any Other Benefit Plan or organization an amount it shall determine to be warranted, if payments that should have been made by the Plan have been made by such Other Benefit Plan or organization.

12.12 Right of Recovery.

The Plan may pay benefits that should be paid by Other Benefit Plans. In this case, this Plan may recover the amount paid from the Other Benefit Plans, the Employee, or from the Spouse or Child on whose behalf the payment was made. That repayment will count as a valid payment under the Other Benefit Plan. Further, this Plan may pay benefits that are later found to be greater than the allowed amount. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

13. THIRD-PARTY LIABILITY/SUBROGATION/RIGHT OF REIMBURSEMENT

This Section generally applies to self-insured or self-funded benefits under the Plan. For insured benefits, the insurance company may have similar provisions as part of the insurance contract. Subrogation/Reimbursement means a process through which the Plan attempts to collect reimbursement for any benefits or payments made under the Plan for which the person at fault or that person's liability insurance policy is legally responsible. The Plan has an equitable first lien on any recovery. The Plan's portion of any recovery is held in constructive trust for the Plan's exclusive benefit.

13.1 The Plan's Right to Recover Payments.

13.1.1 In General. There may be times that someone else causes or is responsible for an injury or illness sustained by you or your Spouse and/or Children. Typical examples include, but are not limited to, injuries sustained:

(A) In an automobile accident caused by another person

(B) In an accident on someone else's property

In such cases, for example, the other person's car insurance or property insurance may be responsible for paying all or part of the resulting health bills. This Section applies when a third party causes or is responsible for you or your Spouse and/or Child's injury or illness. The term "third party" includes all persons, entities, and sources liable for the same injury or illness for which the Plan paid benefits (whether under tort law, contract law, statute, or otherwise), including, but not limited to: wrongdoers; wrongdoers' insurance coverage; you or your Spouse and/or Child's liability insurance coverage; uninsured, underinsured, and no-fault motorist coverage, whether your coverage or the coverage of your Spouse and/or Child, the parents and/or guardians of your Spouse and/or Child, or a third party; health payments; worker's compensation coverage; and other benefit plan coverage.

By enrolling in the applicable Health Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the terms and conditions set forth in this Section with respect to the amount of covered expenses paid by the applicable Health Plan. Failure by a covered person to follow the terms and conditions set forth in this Section may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the applicable Health Plan of an amount up to the aggregate amount of reimbursable payments that has not been reimbursed to the applicable Health Plan.

13.1.2 Equitable Lien and other Equitable Remedies. The Plan will have an equitable right of reimbursement imposed against all recoveries which you or your Eligible Family Members may recover from a third party by any means. The Plan's share of such an identified fund will be that portion of the total recovery that is due the Plan for benefits paid due to your resulting health bills. The Plan will have an equitable lien on all such recoveries from a third party equal to the Plan's share of the fund as described above. Neither you nor your Eligible Family Members may claim or impose any defenses of any kind against the Plan's recovery as provided for in this Section, including, without limitation, the equitable "make whole doctrine" or the equitable "common fund doctrine." The Plan fiduciaries will have complete discretionary authority to interpret this Section. This and any other provisions of the applicable Health Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (1/8/2002).

If the third party or insurer makes payment before benefits are paid under the Plan, the benefits provided by the Plan will be reduced to the extent of the third party's or insurer's payment.

The Plan has an equitable first lien on any recovery you may receive or become entitled to receive from a third party and you will hold the Plan's portion of the recovery in constructive trust for the benefit of the Plan. The

equitable first lien will remain in effect until the Plan Administrator acknowledges and agrees upon payment to the Plan and releases the equitable first lien. The equitable first lien may not be for an amount greater than the amount of benefits paid under the Plan. However the Plan Administrator may in its sole and exclusive discretion consider your petition for a reduction of the Plan's equitable first lien. Any recoveries will be held in constructive trust for the benefit of the Plan.

13.1.3 Assignment of Rights (Subrogation). Because a determination regarding fault or responsibility may take time to make, you have the option of submitting the health bills to this Plan for payment before the determination is made. As a condition of making health benefit payments for an injury or illness sustained in the above circumstances, you and your Eligible Family Members (or the parents and/or guardians of your Children) automatically assign to the Plan any rights and remedies you or they may have against any third party; agree to reimburse the Plan in the event you or they receive any settlement, judgment, award or payment relating to the illness or injury; agree to help the Plan to recover benefits the Plan has paid out on your or their behalf; provide information concerning any third party which may be obligated to pay benefits for the same injury or illness for which the Plan has paid or may pay benefits; cooperate fully in the Plan's exercise of its right to recovery; and refrain from doing anything that would prejudice the rights of the Plan to recover monies to which it is entitled. This is so that this Plan can collect reimbursement for any benefits it might make for the injury or illness that the third party caused or is responsible for. When the third party makes any payment, the Plan is entitled to be repaid first. You and your Eligible Family Members (or parents and/or guardian of your Children, your/their estate and/or your/their legal representative) are obligated to reimburse the Plan up to the amount of benefits the Plan paid, regardless of: whether the payment received from the third party is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement; whether the third party or its insurer admits liability; the label the payment is given; or whether you, your Eligible Family Members (or their parents and/or guardian) are made whole by the recovery. This is called the Plan's equitable right of reimbursement.

The Plan will be subrogated, to the extent of any payment under the Plan, to all of your rights, the rights of your Eligible Family Members and their parents and/or guardian to recover all amounts paid by the Plan for an injury or illness which was caused by, or is the responsibility of, any third party. This right is the Plan's equitable right of subrogation, which is the right of the Plan to seek payment from a third party on your behalf. The equitable right of subrogation allows the Plan to pursue any claim in which you or your Eligible Family Member may have against any third party, regardless of whether you or your Eligible Family Members choose to pursue such claim.

You, your Eligible Family Members, your estate, and your legal representative may not do anything to prejudice the Plan's rights to recovery and will do everything necessary to secure such rights. The Plan's equitable right of recovery, either by subrogation or reimbursement, will apply to the first monies recovered from each third party and such first monies, regardless of label, will be deemed to be paid for the same illness or injury for which benefits were paid by the Plan. All monies recovered belong entirely to the Plan until the Plan is fully reimbursed for benefits paid, even if: you, your Eligible Family Members or their parents and/or guardian have not been made whole; and/or attorneys retained by you, your Eligible Family Members or their parents and/or guardian have not been paid. In its sole discretion, the Plan Administrator may choose to permit payment of all or part of attorneys' fees incurred in obtaining payment or reimbursement.

13.1.4 Right or Offset or Overpayment. In the event that you, your Eligible Family Members or their parents and/or guardians, or legal representative retained by you, your Eligible Family Members or their parents and/or legal guardians refuse to reimburse the Plan, pursuant to this Section, after recovering from any third party who caused, or is responsible for, the injury or illness, the Plan Administrator may, in its sole discretion, choose to offset the amount of the reimbursement that the Plan is entitled to against any future benefit amounts that you or your Eligible Family Members may become entitled under the Plan until the Plan's lien is satisfied. The Plan shall have the fullest right by law to recover any payments that were made to, or on behalf of, a covered individual and which causes an overpayment to be made.

13.1.5 Jurisdiction. By accepting benefits (whether the payment of such benefits is made to a covered person or made on behalf of the covered person to any provider) from the applicable Health Plan, you or your Eligible Family Members agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you and your Eligible Family Members hereby submit to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

13.2 Signed Subrogation Agreements.

If a third party caused, or is responsible for, an injury or illness sustained by you or your Spouse and/or Children, the Plan requires a signed Subrogation Agreement or other document to protect the Plan's subrogation and reimbursement rights before the Plan pays any benefits over $500. You must agree to cooperate with the Plan as reasonably requested. In the event that you settle your claim with the third party, this Plan will not make any payments for the health bills related to that injury or illness. The Plan Administrator may refuse to pay benefits, or cease to pay benefits, on your or your Spouse and/or Children's behalf if (i) you, your Spouse and/or Children, or (ii) the parents and/or guardian of your Spouse and/or Children, or (iii) legal representative retained by you, your Spouse and/or Children, or (iv) the parents and/or guardian of your Spouse and/or Children, refuse to sign any document deemed by the Plan Administrator to be relevant in protecting the Plan's subrogation or reimbursement rights or fail to provide relevant information to the Plan when requested. The term "information" includes, but is not limited to, any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan's rights.

13.3 Interpretation.

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the applicable Health Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

14. DISCLOSURE OF PROTECTED HEALTH INFORMATION

14.1 Introduction.

The Employer is committed to protecting the privacy and confidentiality of the health information for you and your dependents that is created or received in the administration of the group health benefits offered under this Plan. Federal legislation known as the Health Insurance Portability and Accountability Act of 1996 and the underlying privacy and security regulations issued by the U.S. Department of Health and Human Services (in the aggregate referred to as "HIPAA" in the Section) provide additional protection for individually identifiable health information (referred to as "Protected Health Information" or "PHI"). The Plan maintains a "HIPAA Notice of Health Information Privacy Practices" ("HIPAA Notice") that provides a description of how the Employer and the Plan may use or disclose your PHI, as well as your health information rights under HIPAA.

To the maximum extent permitted by HIPAA, any Business Associate with respect to the Plan, and any health insurance issuer or health maintenance organization ("HMO") with respect to the Plan, may disclose PHI to the Plan Sponsor, subject to the terms and conditions of HIPAA and the Employer's HIPAA Privacy and Security Policies and Procedures.

Throughout this Section, various terms are used repeatedly, some of which may be capitalized. These terms have specific and definite meanings ascribed under HIPAA.

14.2 Protected Health Information (PHI).

PHI includes information that the Plan creates or receives that relates to the past, present, or future health or medical condition of an individual that could be used to identify the individual. PHI must also either identify the individual or provide a reasonable basis to believe the information at issue can be used to identify the Individual. PHI pertains to both living and deceased Individuals. PHI includes electronic PHI which is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc.).

14.3 Use and Disclosure of PHI.

The Plan can use or disclose PHI only in a manner consistent with HIPAA, which generally is for purposes of Payment and Health Care Operations. Payment means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the Plan, and other health care utilization review activities. Health Care Operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities. PHI also may be used or disclosed as specifically permitted by HIPAA, including the following examples:

(A) The Plan may share PHI with government or law enforcement agencies when required to do so or when required to in a court or other legal proceeding;

(B) The Plan may share PHI to obey Workers' Compensation laws; and

(C) The Plan may share PHI with the individual if the individual requests access to PHI as described below.

In other situations, the Plan will ask for the individual's written authorization before using or disclosing PHI.

14.4 Conditions of Disclosure.

The Plan may disclose PHI to the Plan Sponsor (including certain members of the Plan Sponsor's workforce) only to perform administrative functions on behalf of the Plan in a manner consistent with HIPAA requirements. In this regard, the Plan Sponsor, by executing this Plan document, hereby provides certification to the Plan that the Plan Sponsor will appropriately safeguard and limit the use and disclosure of PHI that it receives from the Plan only to perform plan administration functions. Specifically, the Plan Sponsor agrees to:

(A) Use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA.

(B) Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information.

(C) Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan.

(D) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware.

(E) Make available information in accordance with the HIPAA Rules regarding individual access to PHI.

(F) Make available PHI for amendment in accordance with the HIPAA Rules.

(G) Make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual.

(H) Make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules.

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

(J) Ensure adequate separation between the Plan and Plan Sponsor.

(K) To the extent required by HIPAA, ensure compliance with the safeguard and other requirements specified under HIPAA relating to hybrid entities (see below) and the healthcare component of the Plan.

(L) To the extent that the Plan Sponsor creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor will report to the appointed Security Official any security incident of which it becomes aware and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions of Section 14.7 below are satisfied.

14.5 Hybrid Entity Election.

This Plan document is a wrap plan document that incorporates by reference various separate welfare benefit programs, some of which are group health plans and others are non-group health plans. As a result, HIPAA may treat this wrap plan document as offering a healthcare component and a non-healthcare component and consequently, it is considered a "hybrid entity" as defined under Section 45 CFR 164.103 of HIPAA. In this case, the healthcare component of this Plan document consists of the group health plans (including the Medical, Dental, Vision and Health Care Spending Account Plan). The non-healthcare component of the Plan consists of all other benefits under the Plan, including the LTD, Life Insurance, Dependent Care Spending Account and the Cafeteria Plan. The Plan and Employer intend to comply with HIPAA with respect to only the healthcare component of the Plan and to ensure adequate separation between the healthcare component and the non-healthcare component and to clarify that such healthcare component and non-healthcare component are separate and distinct plans. In this regard and to the extent required by HIPAA, the Plan and the Employer will ensure compliance with the safeguard requirements relating to hybrid entities as set forth in Section 45 CFR 164.105(a) of HIPAA and in the Plan's HIPAA Privacy Policies and Procedures.

14.6 Workforce of the Plan.

The Plan has designated a Privacy and Security Official - (please contact the Plan Administrator for the name and address of such official). The Privacy and Security Official is the privacy and security fiduciary responsible for the Plan's compliance with the HIPAA Privacy and Security Rules. Compliance includes ensuring that appropriate administrative, physical and technical procedures and safeguards are in place to protect PHI and to reasonably and appropriately protect the integrity, confidentiality and availability of any electronic PHI that the Plan Sponsor creates, receives, maintains or transmit on behalf of the Plan. This also includes ensuring that certain members of the Employer's Workforce comply with, are trained in and appropriately handle PHI and electronic PHI under the HIPAA Privacy and Security Rules, and understand the sanctions for HIPAA violations.

14.7 Adequate Separation between Plan and Plan Sponsor.

The Plan Sponsor shall limit access to PHI to only those Plan Sponsor employees who are involved with plan administration. The Plan Sponsor shall keep an updated list of those authorized to receive PHI.

No other persons will have access to PHI. The specified employees (or classes of employees) will only have access to, and may only Use PHI to the extent necessary to perform their employment duties relating to any Plan Administration Functions that the Plan Sponsor performs for the Plan. In the event that any such employee does not comply with the provisions of this Section, the Plan Sponsor agrees that such person or entity will be subject to disciplinary action for non-compliance pursuant to the Plan Sponsor's discipline and termination procedure.

The Plan Sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan

14.8 Individual Rights.

You can learn more about these HIPAA Privacy and Security laws or your legal rights regarding your health information by reviewing a copy of the Plan's Notice of Privacy Practice that was previously sent to you and included as an Appendix D to this Plan document or by contacting the HIPAA Privacy or Security Official (who also can provide you with another copy of the Notice of Privacy Practice).

14.9 Violations of HIPAA and Breach Notification.

If Plan Sponsor becomes aware of violations of the HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or Security Officer appointed by Plan Sponsor to consult with the person who has violated the privacy or security rules with respect to his or her obligations under the privacy or security rules. A person who violates these privacy or security rules may be subject to discipline up to and including discharge. The Plan will comply with the requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and its regulations to provide notification to affected individuals, HHS, and the media, when required, if the Plan or one of its business associates discovers a breach of unsecured PHI.

15. YOUR RIGHTS UNDER ERISA

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants will be entitled to the right described in this Section.

15.1 Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents including: insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all documents governing the operation of the Plan upon written request to the Plan Administrator, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's Annual Report (Form 5500). The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

Receive a 4-page Summary of Benefits and Coverage and Uniform Glossary per the ACA.

15.2 COBRA and HIPAA Rights

Continued health care coverage for you, your Spouse and/or Children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Spouse and/or Children may have to pay for such coverage. Review Sections 7.2 and 9.7 above regarding rules governing your COBRA Continuation Coverage rights.

15.3 Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The persons who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest all Plan Participants and beneficiaries.

No one, including your Employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit, or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

15.4 Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 calendar days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the Qualified Status of a medical child support order, you may file suit in federal court.

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

15.5 Assistance With Your Questions

If you have any questions about your Plan, you should contact the third-party administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

16. GENERAL CLAIMS REVIEW AND APPEALS PROCEDURES

16.1 Claims for Benefits.

You generally should follow the claims review and appeal procedures set forth in the applicable Supplemental Plan Documents with respect to any claim for benefits under the Plan. There will be no liability for the payment of benefits imposed upon the officers, directors, employees, or stockholders of the Employer and, to the extent that benefits are provided through insurance, your right to receive such benefits will be solely governed by the terms of the applicable Supplemental Plan Documents and the Plan, Employer or Plan Administrator will have no obligation to provide such benefits to you.

However, the claims review and appeal procedures that are described in the remaining provisions in the Section 18 will apply in the event that (i) the claim relates to the administration of this Plan, (ii) a particular Plan does not prescribe a claims procedure that satisfies ERISA or other applicable law requirements (e.g. Health Care Reform), or (iii) the Plan Administrator determines that the claims procedures specified below should apply in lieu of the claims procedures described in a particular Plan. The timeframes for filing or responding to claims as set forth in this Section may be modified by the Claims Administrator to the extent necessary to comply with applicable laws (e.g., extended timeframes during the COVID-19 outbreak period).

16.2 Initial Claims.

A claimant may file a claim, either in writing or electronically, which claim must include the following information:

(A) The name and address of the claimant;

(B) The specific basis for the claim;

(C) A specific reference to the applicable Plan and pertinent plan provision upon which the claim is based; and

(D) Any additional material or information which the claimant desires to submit in justification of the claim.

You may designate a representative to act on your behalf in pursuing a benefit claim or appealing a denied benefit claim. Please contact the Claims Administrator to determine what you need to do to designate a representative.

Upon receipt of a claim, the Claims Administrator will review and render a claim determination. The actual party reviewing your claim and the deadlines throughout this claim process differ based on the stage of the claim (initial, appeal, external review) and whether the claim involves group health plan benefits, disability benefits or all other types of claims, all of which is further explained below.

16.3 Claim Administrator's Initial Determination.

The Plan Administrator, or its designated claims administrator, (collectively referred throughout this Section 16 as "Claims Administrator") will notify a claimant of its claim determination no later than the deadlines specified below. These deadlines differ based on whether the claim involves group health plan benefits, disability benefits or all other types of claims:

16.3.1 Health Benefit Claims. If the claimant files a claim for benefits under the applicable Health Plans or Health FSA, the following shall apply:

(A) *Urgent Care*. An urgent care claim is a claim in which a delayed determination (i) could seriously jeopardize the life or health of the affected individual or the ability of the individual to regain maximum function, or (ii) in the opinion of an informed physician, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan shall defer to the attending physician with respect to the decision as to whether a claim constitutes "urgent care" for purposes of this Section. Approval or denial of an initial urgent care claim will be furnished to a claimant as soon as possible taking into account the medical urgency, but not later than 72 hours after receipt of the claim. Any denial will contain a description of the expedited review process. This notice may be given orally, in which case a written notice will be sent within 3 days of the oral notice. If more information is needed from a claimant, the Claims Administrator will notify a claimant not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. A claimant then has at least 48 hours to provide the information. The Claims Administrator will notify a claimant of the decision not later than 48 hours after the earlier of (i) the receipt of the specified information, or (ii) the end of the period afforded a claimant to provide the additional information.

(B) *Concurrent Care*. Concurrent care is an ongoing course of treatment which is to be provided over a period of time or number of treatments. Approval or denial of an initial claim involving concurrent care will be sent to a claimant sufficiently in advance of the reduction or termination of the benefit to the claimant to appeal and obtain a decision on review before the benefit is reduced or terminated. In case of an urgent care claim to extend the concurrent care beyond the end of the approved period of treatment, the Claims Administrator will notify the claimant of its determination no later than 24 hours after receipt of the claim, provided the claim is made at least 24 hours before the concurrent care otherwise is scheduled to terminate.

(C) *Pre-Service Claim*. A pre-service claim is a claim that requires pre-approval as a condition of coverage. Approval or denial of an initial pre-service claim will be sent to a claimant within 15 calendar days after receipt of the claim, unless an extension is required. The 15-day period may be extended once up to 15 calendar days. A claimant will be notified of any such extension before the expiration of the initial 15 day period. If the extension is required due to a claimant's failure to provide the necessary information, the Claims Administrator will describe the required information. A claimant will have at least 45 calendar days from receipt of the notice to provide the information. If a claimant fails to follow the Plan's procedures for filing a pre-service claim, the Claims Administrator will notify such claimant of such failure no later than 5 days (24 hours if the pre-service claim also is an urgent care claim) following receipt of the claim. The preceding sentence only will apply in the case of a claim that (i) is received by the person responsible for handling benefit matters; and (ii) names a specific claimant, a specific medical condition or symptom and a specific treatment, service or product.

(D) *Post-Service Claim*. A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to a claimant within 30 calendar days after receipt of the claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to a claimant's failure to provide the necessary information, the Claims Administrator will describe the required information. A claimant will have at least 45 calendar days from receipt of the notice to provide the information.

16.3.2 Disability Benefit Claims. Approval or denial of an initial disability claim under the LTD Plan will be sent to a claimant within 45 calendar days after receipt of the claim, unless extensions are required. The 45-day period may be extended twice, up to 30 calendar days each, provided the extensions are due to matters beyond the control of the Plan. A claimant will be notified of the first extension before the expiration of the initial 45-day period. A claimant will be notified of the second extension before the expiration of the first 30-day extension period. This extension notice will explain: (i) the circumstances requiring an extension; (ii) the date by which the Claims Administrator expects to make the benefit determination; (iii) the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on a claim; and (iv) the additional information needed to resolve those issues. A claimant will be afforded at least 45 days within which to provide any specified information.

16.3.3 All Other Claims. Approval or denial of any other type of claim, e.g., a claim for benefits under the Life Insurance Plan or Cafeteria Plan, or regarding eligibility requirements under this Plan, will be sent to a claimant within 90 calendar days after receipt of the claim, unless an extension is required. The 90-day period may be

extended once up to 90 calendar days, provided the Claims Administrator determines that special circumstances require an extension of time for processing the claim. A claimant will be notified of the extension before the expiration of the initial 90-day period. The extension notice will explain the circumstances requiring an extension and the date by which the Claims Administrator expects to make the benefit determination.

16.4 Claimant's Deadline for Filing an Appeal of a Denied Claim.

A claimant may request, either in writing or electronically, a full and fair review of an initial decision denying his or her claim generally within:

(A) 180 days following receipt of a denial of a claim involving group health plan benefits or disability benefits; or

(B) 60 days following receipt of a denial of any other type of claim.

16.5 Appeal Procedures.

On appeal, the following procedures will apply:

(A) During the review, a claimant may represent himself or herself or will have the right to appoint a representative, provided that the claimant is responsible for all of fees and expenses of such representative.

(B) A claimant will have reasonable access (free of charge and upon request) to copies of all documents, records and other information relevant to his or her claim for benefits.

(C) A claimant will be provided the opportunity to submit, and any review will take into account, all comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(D) The review of a denied claim involving a group health plan benefit or disability benefit will be conducted by an independent fiduciary who is neither the individual who made the initial decision to deny the claim nor a subordinate of that individual. Such reviewer will not give deference to the original decision to deny the claim. If the decision to deny the claim was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted, nor a subordinate of an individual who was consulted, in connection with the original decision to deny the claim.

(E) With respect to medical or disability benefit claims, the Plan Administrator shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved with making the claims decisions. Accordingly, the Plan Administrator's decision regarding hiring, compensation, termination, promotion or other similar matters with respect to any claims adjudicator or medical expert, must not be made based upon the likelihood that the individual will support a denial of benefits, nor shall the Plan Administrator contract with a medical expert based on the expert's reputation for outcomes in contested cases other than based on the expert's profession qualifications.

(F) In the case of an urgent care claim for health benefits, the claimant may request expedited review of a denied claim whereby the request may be made orally or in writing and all necessary information may be transmitted between the Plan and the claimant by telephone, facsimile or other similar expeditious method.

(G) The Claims Administrator will identify to the claimant the medical or vocational experts whose advice was obtained in connection with the denied claim, even if the advice was not relied upon in making the benefit determination.

(H) For disability and medical benefit claims, the Claims Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim or any new or additional rationale on which the decision was based. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date the Claims Administrator notifies the claimant of its decision (see Section 16.6 below) to provide the claimant a reasonable opportunity to respond prior to that date.

16.6 Claims Administrator's Deadline for Deciding an Appeal.

The Claims Administrator will notify the claimant of its decision regarding the claimant's appeal as follows:

16.6.1 Health Benefit Claims:

(A) For urgent care claims – the Claims Administrator will notify a claimant of the decision as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the claim for review.

(B) For pre-service claims – the Claims Administrator will notify a claimant of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 calendar days after receipt of the initial claim for review. However, if the Claims Administrator provides the claimant with two level of appeals, then the Claims Administrator will notify the claimant, with respect to any one of such two appeals, of its decision not later than 15 days after receipt by the Plan of the claimant's request for review.

(C) For post-service claims – the Claims Administrator will notify a claimant of the decision within a reasonable period of time, but not later than 60 calendar days after receipt of the initial claim for review. However, if the Claims Administrator provides the claimant with two level of appeals, then the Claims Administrator will notify the claimant, with respect to any one of such two appeals, of its decision not later than 30 days after receipt by the Plan of the claimant's request for review.

16.6.2 Disability Benefit Claims: For disability benefit claims – the Claims Administrator will notify a claimant of the decision within a reasonable period of time, but not later than 45 calendar days after receipt of the claim for review, unless the claims administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 45 day period. In no event will the extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination of a claimant's appeal.

16.6.3 All Other Claims: For all other type of claims (not involving health or disability benefits):

(A) The Claims Administrator generally will notify the claimant of the decision within a reasonable period of time, but not later than 60 calendar days after receipt of the claim for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 60-day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination of a claimant's appeal.

(B) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, subsection (c)(1) immediately above shall not apply. The appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for a review, unless the request for review is filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing the claim, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If the Claims Administrator determines that such an extension of time is required due to special circumstances, the Claims Administrator will notify the claimant, in writing, of the extension prior to the commencement of the extension, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The Claims Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

16.7 Notice of a Denied Claim.

The Claims Administrator's notice of its decision to deny a claim, during its initial claim and/or subsequent appeal reviews, will set forth:

(A) The specific reasons for the decision and a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim.

(B) References to specific provisions in this Plan document and the applicable Supplemental Plan Documents upon which the decision is based.

(C) For a notice involving the Claims Administrator's initial decision on a claim -- a description of any additional material or information necessary for the claimant to perfect his or her claim along with an explanation of why such material or information is necessary, and an explanation of claim review procedures under the Plan and the time limits applicable to such procedures.

(D) A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following a review of a denied claim, including any applicable contractual limitations period that applies to the claimant's right to bring an action involving a disability benefit claim, including the calendar date on which the contractual limitations period expires for the claim.

(E) For medical and disability benefit claims, the specific or internal rule, guideline, protocol or similar criterion, if any, that was relied on in making the decision, or a statement that the rule, guideline, protocol or similar criterion will be provided to the claimant free of charge.

(F) If the decision is based on a medical necessity or an experimental treatment limit or exclusion, either an explanation of the scientific or clinical judgment for the determination that applies the Plan to the claimant's medical or disability circumstances or a statement that the explanation will be provided free of charge on request.

(G) The identity and views of any medical or vocational experts whose advice was obtained by the Claims Administrator in the process of deciding the medical or disability-related claim, regardless of whether Claims Administrator relied upon such advice. The Claims Administrator also will provide an explanation of the basis for not agreeing with or following the views presented by the claimant to the Plan of health care professionals or vocational professionals treating or evaluating the claimant, or with the Plan's own medical or vocation experts.

(H) For a disability claim, an explanation of the Claims Administrator not agreeing with or following the disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(I) With respect to an adverse benefit determination involving a claim for disability or medical benefits, the Plan shall provide any claim notifications in a culturally and linguistically appropriate manner in accordance with applicable law, including:

(1) The Claims Administrator must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(2) The Claims Administrator must provide, upon request, a notice in any applicable non-English language; and

(3) The Claims Administrator must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the federal agencies.

(J) With respect to claims for medical benefits under the Medical Plan:

(1) Any notice of an adverse benefit determination must include the following information:

(a) the date of service;

(b) the health care provider;

(c) the claim amount (if applicable);

(d) description on how to request the diagnosis and treatment codes with the corresponding meaning of such codes;

(e) the reason(s) for denial must include the denial code and its corresponding meaning;

(f) description of the Plan's standard, if any, used in denying the claim;

(g) a summary of the Claim Administrator's discussion regarding its final decision to deny the claim;

(h) a description of the available internal appeals and external review processes, including information regarding how to initiate such processes; and

(i) disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Health Care Reform Act to assist claimants with the internal claims and appeals and external review processes.

(2) If the Medical Plan fails to strictly adhere to the claim process requirements set forth in this Section, the claimant shall be deemed to have exhausted the internal claims and appeal process, regardless of whether the Medical Plan asserts that it substantially complied and the claimant may initiate an external review and pursue any available remedies under applicable law unless the violation was: (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the Medical Plan's control; (iv) in the context of an ongoing good faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. In the event that the Medical Plan claims the purported violation is covered under the circumstances described in (i)-(v) of the immediately preceding sentence, the claimant shall be entitled, upon written request, to an explanation of the Medical Plan's basis for asserting that it meets the requirements of (i)-(v) of this subsection, so that the claimant can make an informed judgment about whether to seek immediate review. If an external reviewer or court rejects the claimant's request for immediate review on the basis that the Medical Plan met the standards in (i)-(v), the claimant shall have the right to resubmit and pursue the internal appeal of his or her claim.

(3) The Medical Plan shall provide the claimant with continued coverage under the Medical Plan pending the outcome of the internal appeal. For this purpose, the Medical Plan may not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

(4) A claimant shall have the right to file a request for an independent, external review of the Medical Plan's decision. The claimant must make this request within 4 months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination. The Medical Plan shall comply with either a State's external review process or the Federal external review process. If a State's external review process applies and is binding on a fully-insured group health option offered under this Medical Plan, and, at a minimum, after December 31, 2011, such process includes the consumer protections in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010, then the issuer of such fully-insured option under the Medical Plan shall be required to comply with that State's external review process (and the Federal external review process will not apply). A description of the minimum consumer protections under the NAIC Uniform Model Act are set forth in the Health Care Reform Act's related regulations published at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.136, and DOL Technical Release 2010-01, as amended by DOL Technical Release 2011-02. If a State's external review process does not apply to an option offered under the Medical Plan

(e.g. because the option is a self-funded option or the State's external review does not meet the minimum consumer protections of the NAIC Uniform Model Act after December 31, 2011), then the Federal external review process will apply; provided, however, for claims for which external review has not been initiated before September 20, 2011, such Federal external review shall only apply to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage. The Federal external review process is similar to the process set forth under the NAIC Uniform Model Act and is explained in detail under the Health Care Reform Act's related regulations (published at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.136) and DOL Technical Release 2010-01. Generally, all adverse benefit determinations shall be subject to the external review process requirements, except for a decision relating to an individual's failure to meet the requirements for eligibility under the terms of the Medical Plan (e.g. worker classification and similar issues).

(K) The following statement if the claim involves health care or disability benefits: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."

16.8 General Claim Provisions.

Notwithstanding anything to the contrary in this Plan document and the applicable Supplemental Plan Documents, the following provisions in this Section 16.8 shall apply to all claims involving the Plan during both the Claims Administrator's initial claim review or appeal review.

16.8.1 Finality of Decisions. The Claims Administrator has full discretion in determining any matter regarding a claim for Benefits or other claims involving the Plan. The decision of the Claims Administrator upon review of any claim shall be binding upon a claimant, his or her heirs and assigns, and all other persons claiming by, through or under a claimant.

16.8.2 Limitation of Liability. There will be no liability for the payment of benefits imposed upon the officers, directors, employees, or stockholders of the Employer and, to the extent that benefits are provided through insurance, your right to receive such benefits will be solely governed by the terms of the applicable Supplemental Plan Documents and the Employer, and Plan Administrator will have no obligation to provide such benefits to you.

16.8.3 Limitation of Claims Review and Appeal Procedures. Except as otherwise required under and subject to the terms of a Plan, including Sections 9.9.4 and 9.10.5 regarding FSA claims, any claim under this claims review and appeal procedures must be submitted within 12 months from the earlier of:

(A) the date on which the claimant learned of facts sufficient to enable him to formulate such claim, or

(B) the date on which the claimant reasonably should have been expected to learn of facts sufficient to enable him to formulate such claim.

16.8.4 Limitation on Court Action. Any suit brought to contest or set aside a decision of the Claims Administrator is to be filed in a court of competent jurisdiction within one year from the date of the receipt of written or electronic notice of the Claims Administrator's final decision. Service of legal process shall be made upon the Plan by service upon the agent for service of legal process or upon the Claims Administrator.

16.8.5 Legal Action. No legal action to recover Plan benefits or to enforce or clarify rights under the Plan shall be commenced under ERISA Section 502(a)(1)(B), or under any other provision of law, whether or not statutory, until a claimant first exhausts the claims review and appeal procedures available to him or her under the Plan.

16.8.6 Judicial Review. The Plan gives the Plan Administrator, or any Claims Administrator or other person or entity to whom the Plan Administrator has delegated any of its duties in writing, full discretion and sole authority to make the final decision in all areas of plan interpretation and administration, including eligibility for benefits, the level of benefit provided, and the meaning of all Plan language and the ability to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The decision of the Plan Administrator or its delegate is final and binding on all those dealing with the plan and if challenged in court,

the Plan intends for the Plan Administrator's or its delegate's decision to be upheld unless it is deemed to be arbitrary and capricious.

16.8.7 Forfeiture of Uncashed Checks. If the Plan (through the Plan Administrator or its Claim Administrator) makes payment to you (and/or to your Eligible Family Members or to a provider on your behalf) of an approved benefit claim and the check for such benefit claim remains uncashed (regardless of the reason) for a period of more than one (1) year after the issue date of the check, then you (and/or your Eligible Family Members or the provider) will forfeit all rights for reimbursement or payment of such claim under the terms of Plan and you will not be entitled to reinstate your rights with respect to such claim at any time thereafter. Also, the Plan requires that you submit your initial claim for payment within 12 months after the date of service relating to your benefit claims. If you submit your claim after this 12-month period, then you (or your Eligible Family Members or the provider acting on your behalf) will forfeit all rights to payment or reimbursement under the Plan, and the Plan will deny such benefit claim.

16.8.8 Special Rulings. In order to resolve problems concerning the Plan and to apply the Plan in unusual factual circumstances, the Claims Administrator may make special rulings. Such special rulings will be in writing on a form to be developed by the Claims Administrator. In making its rulings, the Claims Administrator may consult with Claims Administrators, legal, accounting, investment, and other counsel or advisers. Once made, special rulings shall be applied uniformly, except that the Claims Administrator will not be bound by such rulings in future cases unless the factual situation of a particular case is identical to that involved in the special ruling. Special rulings shall be made in accordance with all applicable law and in accordance with the Plan. It is not intended that the special ruling procedure will be a frequently used device, but that it should be followed only in extraordinary situations. The Claims Administrator at all times will have the final decision as to whether or not to apply this special ruling feature.

17. MISCELLANEOUS PROVISIONS

17.1 Conformity with Governing Law.

The Plan will be construed, administered, and enforced according to the laws of the United States and to the extent permitted by such laws, the laws of the State of Michigan. Any provision of this Plan which, on its effective date, is in conflict with an applicable federal law, is deemed to be amended to conform with the minimum requirements of that law.

An individual whose employment is covered under and subject to a collective bargaining agreement generally is eligible to participate in this Plan to the extent that the terms of such agreement expressly requires and provides for coverage under the Plan. Any union eligible Employee who is enrolled in this Plan may request a copy of the collective bargaining agreement from the Plan Administrator.

17.2 Assignment.

Notwithstanding anything to the contrary in the Plan document or Supplemental Plan Documents, no right or benefit provided for under this Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so will be void. Specifically, a Plan Participant may not assign any right, demand, claim or cause of action under federal or state law, including any derivative claim under ERISA or other federal a state law, to a provider or other party, against the Plan, Employer, Plan Sponsor, Plan Administrator, fiduciary or Claims Administrator.

However, this anti-assignment provision does not and will not be construed to restrict or forfeit any subrogation rights of the Employer under the Plan. The Plan reserves the right to pay benefits, in its sole discretion, directly to a provider of services, instead of to the Participant, as a convenience to the Participant. In such event, the Employer shall be relieved of all further responsibility with respect to that particular expense. A Claims Administrator's review, under the Plan's claims review and appeal procedures, of a claim directly with a provider, as the designated representative of the participant, is not intended, and shall not be construed as a waiver of these anti-assignment provisions.

17.3 Plan is not a Contract of Employment.

This Plan is not deemed to constitute an employment contract between Employer and an Employee or to be consideration for or an inducement or condition of the employment of any Eligible Employee. Nothing in this Plan

shall give any individual the right to be retained in the service of Employer or to interfere with the right of Employer to discipline or discharge any individual from its employ at any time. You have the right to terminate your employment at any time for any reason, and the Employer has a similar right with regard to terminating your employment.

17.4 Non-waiver of Plan Provisions.

Failure of the Plan Administrator to insist upon compliance with any provision of this Plan at any given time or under any given set of circumstances will not operate to waive or modify such provision, or in any manner whatsoever to render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances are or are not the same.

17.5 Entire Plan and Summary Plan Description.

This Plan document, referenced appendices and Supplemental Plan Documents constitute the entire Plan and Summary Plan Description.

Each year, the Employer furnishes the Employee Benefits Guide to Eligible Employees. Such Guide is considered a Summary of Material Modifications under ERISA. As such, each Guide will be incorporated by reference into this Plan document, until such time as this Plan document is amended and restated.

17.6 Return of Dividends, Premiums or Reserves.

With respect any Other Fully-Insured Plan options which the Employer subsidizes or pays for in full, any dividends, demutualization proceeds, rebates, returned premiums, or reserves credited under an insurance policy shall be the property of the Employer. To that extent, such dividends, return of premiums or reserves or demutualization proceeds do not become assets of the Plan.

17.7 Tax Consequences.

The Employer, Plan Administrator and Plan do not make any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and you shall have no rights against them if any tax consequences contemplated are not achieved.

18. DEFINITIONS

ACA. *ACA* means the Patient Protection and Affordable Care Act of 2010, as amended, including regulatory and sub-regulatory guidance thereunder.

Cafeteria Plan. *Cafeteria Plan* means the Asahi Kasei Cafeteria Plan, which is the formal written cafeteria plan that satisfies Code Section 125 requirements. A summary of the Cafeteria Plan terms are included in Section 9 of this Plan document.

Child(ren). *Child(ren)* means one of the following:

(A) Your natural child.

(B) Your stepchild who is the natural or adopted child of your current Spouse.

(C) Your legally adopted child or a child lawfully placed with you or your Spouse for adoption.

(D) A child over whom you have legal guardianship as long as the child resides with you in a normal parent/child relationship and you claim the Child as a dependent on your most recent Federal income tax return.

(E) A child for whom you are required to provide health insurance under a Qualified Medical Child Support Order or divorce decree.

(F) A child who is physically or mentally incapable of self-support due to an injury or illness that occurred before the age of 26.

Before you may enroll a Child for coverage, he or she also must meet the eligibility requirements set forth in the definition of "Eligible Family Members" below and any other requirements set forth in the applicable Supplemental Plan Document.

Claims Administrator. The insurance carrier, third party administrator or other organization that has been engaged by the Plan Administrator to insure the benefits and/or perform benefit claims processing and adjudication services or carry out other administrative responsibilities one behalf of the Plan (including, but not limited to, enrollment, disenrollment and COBRA services). The applicable Supplemental Plan Documents and the Appendix B identify the name and contact information of the Claims Administrator. The Claims Administrator also could mean the Plan Administrator for those benefits or decisions self-administered by it.

COBRA. *COBRA* means the Consolidated Omnibus Reconciliation Act of 1985, as amended, including regulatory and sub-regulatory guidance thereunder.

COBRA Continuation Coverage. *COBRA Continuation Coverage* means temporary continuation coverage, at the expense of an Eligible Employee or Spouse and/or Children, beyond the date the coverage of the Eligible Employee or Spouse and/or Children would otherwise end under the Plan as guaranteed under COBRA. COBRA Continuation Coverage under the Plan is explained in Sections 7.2 and 9.7 above.

COBRA Qualifying Event. *COBRA Qualifying Event* means any of the following events if it would result in a loss of coverage:

(A) the death of Employee

(B) the loss of eligibility due to:

(1) Termination of the Eligible Employee's employment (except for gross misconduct)

(2) A reduction in the hours the Eligible Employee works (e.g., changing employment status from full time to part time, benefit ineligible position)

(3) The last day of a leave of absence governed by and conforming to the requirements of the Family and Medical Leave Act of 1993, as amended, if the Eligible Employee doesn't return to work at the end of that leave

(4) A divorce or legal separation of the Enrolled Spouse and the Enrolled Employee

(5) A Child no longer meeting the Plan's definition of Child/Eligible Family Member

(6) The Enrolled Employee's entitlement to Medicare less than 18 months before Plan coverage is lost due to termination of employment or reduction in hours worked.

Code. See Internal Revenue Code.

Coordination of Benefits (COB). *Coordination of Benefits* means a payment policy of the Plan that states how benefits will be paid if you or your Spouse or Children are covered under this Plan and another health plan.

Dental Plan. *Dental Plan* means the dental benefit options identified in Appendix B.

Dependent Care FSA. *Dependent Care FSA* is a reference to the Dependent Care Flexible Spending Account offered through the Cafeteria Plan.

EAP. *EAP* means the employee assistance program identified in Appendix B.

Effective Date of Coverage. *Effective Date of Coverage* means the date when an Enrolled Employee and Eligible Family Members' coverage under the Plan begins. The Effective Date of Coverage for this Plan generally is:

(A) If you are a non-union Eligible Employee, as of the first day of the calendar month immediately following or coincident with your first date of employment as an Eligible Employee.

(B) If you are a union Eligible Employee, your coverage will become effective as of the date specified in the Collective Bargaining Agreement that covers your employment. Please contact the Plan Administrator for further information.

However, you must timely complete the enrollment process as established by the Plan Administrator before your coverage will take effect. Please see Section 4, *Eligibility and Enrollment*, above for more information enrollment process requirements.

Eligible Employee. *Eligible Employee* means an Employee who is hired and designated by the Plan Administrator, in its sole discretion, as an active, continuous and regularly schedule to work 30 or more hours of service each week. Notwithstanding anything to the contrary in this Plan document or the Supplemental Plan Documents, the following categories of Employees are **not** eligible to participate in this Plan (except as otherwise required under Appendix C with respect solely to coverage under the Medical Plan):

(A) Any individual for whom the Employer designates as a Part-Time Employee, Variable Hour Employee or Seasonal Employee with respect to all benefits under the Plan. For these purposes:

(1) A Part-Time Employee means an Employee for whom, based on the facts and circumstances at the Employee's start date of employment, the Plan Administrator reasonably expects to work less than 30 hours per week.

(2) A Variable Hour Employee means an Employee, if, based on the facts and circumstances at the Employee's start date of employment, the Plan Administrator cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week because the Employee's hours are variable or otherwise uncertain (including temporary Employees).

(3) Seasonal Employee means an Employee for whom the Employer hires into a position which customarily begins around the same time each year and is reasonably expected to work for a period of six months or less (including, but not limited to intern, co-op or temporary Employees, etc.).

(B) Any Employee who is subject to a written employment agreement with the Employer that specifically excludes participation in the Plan or any portion thereof.

(C) Any individual whose employment is covered under and subject to a collective bargaining agreement, unless such agreement expressly requires and provides for coverage under one or more of the welfare benefit programs described in this Plan document

The Employer, in its sole discretion, may reclassify your employment status during the year if it determines that you are regularly and continuously working more or less hours than what you were initially designated to work as of your hire date or you are transferred to a new position with the Employer. You should notify the Plan Administrator if you believe your employment category should be reclassified. In a situation where the Plan Administrator determines that your classification has changed to the status as an Eligible Employee, your eligibility for and Effective Date of Coverage under the Plan will be applied prospectively only (i.e. you will NOT be entitled to retroactive coverage under the Plan).

Eligible Family Members. *Eligible Family Members* include:

(A) Your legal Spouse.

(B) Children until the last day of the month in which he or she attains age 26 or, if earlier, the date on which such child ceases to be considered your "Child" as defined above (e.g., a child who is no longer your step-child because your spouse is no longer considered your "Spouse" as defined below) **who are**:

(1) Your natural, biological children

(2) Your stepchildren

(3) Legally adopted children (or child in the process of legal adoption)

(4) Children over whom you have legal guardianship

(C) A Child for whom you are required to provide health care coverage under a Qualified Medical Child Support Order.

(D) A Child:

(1) who is physically or mentally incapable of self-support due to an injury or illness that occurred before the age of 26;

(2) who is not married; and

(3) for whom you notify the Employer in writing of the disability condition within 30 days of the end of the month in which your Child turns age 26.

A child is considered mentally or physically disabled if the Claims Administrator determines that the Child is not able to earn his or her own living and thus is not self-supporting because of a mental or physical condition, which started prior to the date he or she reached age 26 and the Child depends primarily on you or your Spouse for support and maintenance. You will be required to provide initial and periodic verification from a physician of a Child's mental or physical condition.

Eligible Individual. An *Eligible Individual* is an Eligible Employee who can establish and make contributions to a Health Savings Account pursuant to Code Section 223 and related IRS regulations and guidance. Generally, you may establish an HSA only if you are considered an Eligible Individual who satisfies each of the following conditions:

(A) You are covered under a qualifying HDHP (e.g., under the Employer's HDHP-HSA option offered under the Medical Plan) as of the first day of the calendar month in which you want to establish the HSA;

(B) You have no other health coverage (except for what is permitted by IRS guidance);

(C) You are not currently enrolled in Medicare, Medicaid or TRICARE;

(D) You have not received medical benefits through the Department of Veterans Affairs (VA) or Indian Health Service (IHS) during the preceding three months; and

(E) You may not be claimed as a dependent on another person's tax return.

Employee. *Employee* means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary staffing employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; and (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer. The term "Employee" does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for a limited period of time following termination of employment, but only to the extent specifically provided elsewhere under this Plan. Notwithstanding anything herein to the contrary, the term Employee shall include any individual who would qualify as an Employee pursuant to this Section but for the fact that such individual is on a leave of absence from the Employer which qualifies under the Family and Medical Leave Act of 1993.

Employer. "*Employer*" means Asahi Kasei America, Inc. and any of the Participating Employers identified in Appendix A (in the aggregate referred to as "Employer"); provided, however, that whenever the Plan indicates that the Employer may or shall take any action under the Plan, Asahi Kasei America, Inc. shall have sole authority to take such action for itself and as agent for and on behalf of all Participating Employers.

Employer-Approved Leave of Absence. "*Employer Approved Leave of Absence"* means any leave of absence by you that the Plan Administrator has approved and specifically agreed in writing to continue your active coverage in a particular benefit option offered under this Plan during such leave period.

Employee Group. *Employee Group* means the Plan Administrator's classification of each Eligible Employee into various employee groups (e.g., based on work location, union v. non-union status, etc.). The type of benefit options and the cost of those benefits available under this Plan will vary depending on the Employee Group. As a result, please carefully review this Plan document, the Appendix B and the applicable Supplemental Plan Documents that apply to your Employee Group to understand which welfare benefit programs are being offered to you and at what cost. The Plan Administrator will provide you with copies of the Supplemental Plan Documents that apply to your Employee Group.

Enrolled. *Enrolled* means formally identified by the Plan Administrator as enrolled in a particular benefit program as the Eligible Employee or an Eligible Family Member, for which the Eligible Employee has paid the Premium Payment required by the Plan at the time that a covered service or supply is rendered to the person. See Section 4, *Eligibility and Enrollment*, for more details.

ERISA. *ERISA* means the Employee Retirement Income Security Act of 1974, as amended, a legislative act defining the fiduciary responsibilities of the people engaged in the administration, supervision and management of welfare and pension plans. ERISA also gives specific rights to participants of welfare and pension plans.

Fiduciary. See *Plan Fiduciary.*

Flexible Spending Accounts. *Flexibility Spending Accounts* means, in the aggregate, the Health FSA and the Dependent Care FSA.

FMLA. *FMLA* means the Family and Medical Leave Act of 1993, as amended, including regulatory and sub-regulatory guidance thereunder.

Full-Time Employee. *Full-Time Employee* means an Eligible Employee for whom the Employer, in its sole discretion, has designated as regularly scheduled to work at least 30 hours or more per week.

Grace Period Feature. *Grace Period* means an additional period of time for you to incur Medical Care or Dependent Care Expenses beyond the last day of the current Plan Year (i.e. December 31). Except as otherwise provided herein, the Grace Period will expire on the March 15 immediately following the close of such Plan Year.

HDHP-HSA. *HDHP-HSA* means options offered under the Medical Plan that meet the requirements of Code Section 223 to be treated as a qualifying high deductible health plan for purposes of Eligible Individuals making or receiving contributions to a Health Savings Account (as defined below).

Health Care Spending Account or Health FSA. A *Health Care Spending Account or Health FSA* is a reference to the General Purpose Health Care Flexible Spending Account ("General Purpose FSA) offered through the Cafeteria Plan. This Employer does not offer a restricted purpose health FSA.

Health Plans. *Health Plans* mean a reference in the aggregate to the Medical Plan, Dental Plan and Vision Plan as described under this Plan document.

Health Savings Account or HSA. *Health Savings Account or HSA* means a tax-favored account owned by the Eligible Individual that is established in accordance with Code Section 223 and related regulations and IRS guidance. For purposes of this Plan and the Cafeteria Plan, the term "HSA" shall include only those HSAs that are linked to the Employer's HDHP-HSA options offered under the Medical Plan and established through and held by the trustee or custodian chosen by the Employer.

HIPAA. *HIPAA* means the Health Insurance Portability and Accountability Act of 1996 (PL 104-191), as amended, including regulatory and sub-regulatory guidance thereunder.

Internal Revenue Code or Code. *Internal Revenue Code* or *Code* means the Internal Revenue Code of 1986, as amended, including regulatory and sub-regulatory guidance thereunder.

Life Insurance Plan. *Life Insurance Plan* means the basic and supplemental/voluntary life and accidental death and dismemberment insurance options identified in Appendix B.

Long-Term Disability Plan. *Long-Term Disability Plan* means the basic long-term disability insurance benefit identified in Appendix B.

Medicaid. *Medicaid* means Title 19 of the United States Social Security Amendments of 1965. Medicaid provides federally subsidized medical care for those who have no other means to pay for necessary medical care. Medicaid is a cost-sharing program, with both federal and state governments sharing in the provision of benefits. Medicaid is operated primarily by the individual states.

Medical Plan. *Medical Plan* means the medical, prescription drug and other medical benefit options identified in Appendix B.

Medicare. *Medicare* means benefits provided under Title 18 of the United States Social Security Act of 1965, as amended from time to time. Medicare is a Federal Health Insurance Program for people aged 65 or older, certain disabled people, or people with End-Stage Renal Disease.

Military Service. *Military Service* means the performance of duty on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which you are absent from employment for a physical examination to determine your ability to perform service in the uniformed services.

Open Enrollment Period. *Open Enrollment Period* means a period during which you may enroll in or change your coverage under the Plan. The Open Enrollment Period will begin and end on dates determined by the Plan Administrator, which will be prior to the beginning of the next Plan Year.

Other Fully-Insured Plans. *Other Fully-Insured Plans* mean, in the aggregate, a reference to the Life Insurance Plan, Business Travel and Accident Insurance Plan and Long-Term Disability Plan.

Participant. See Plan Participant.

Participating Employer. *Participating Employer* means each related entity (as defined under Code Section 414(b), (c), or (m)) who are authorized in writing to participate in the Plan by Asahi Kasei America, Inc. Appendix A identifies each Participating Employer.

Plan. *Plan* means the "Asahi Kasei Health and Welfare Plan" which, together with the Supplemental Plan Documents, is intended to satisfy ERISA §§ 102(a) and 402 and Internal Revenue Code requirements for a written plan document and summary plan description. The terms "Plan," "Plan Document," "SPD/Plan Document" and "Plan Document and SPD" are used interchangeably.

Plan Administrator. *Plan Administrator* means the Employer. The Plan Administrator has sole and final discretion authority to determine eligibility to participate in and receive benefits under the Plan and to interpret the terms of this Plan document and Supplemental Plan Documents, unless such discretionary authority has been delegated to a Claims Administrator through written agreement or has been delegated to an officer or committee of the Employer. The Plan Administrator also has delegated day-to-day Plan operations and management to certain Claims Administrators and the Benefits Department.

Plan Fiduciary. *Plan Fiduciary* means the person or company that has the responsibility to make sure that the Plan's funds are used properly for the benefit of the people Enrolled in the Plan. The named Fiduciary for this Plan is Asahi Kasei America, Inc.

Plan Participant. *Plan Participant* means an Eligible Employee and his or her Eligible Family Members who are properly Enrolled in the Plan and whose active participation has not terminated under any applicable provisions of this Plan. However, only the Eligible Employee shall make any elections under the Plan and receive regular employee communications concerning the administration and benefits provided under the Plan.

Plan Sponsor. *Plan Sponsor* means Asahi Kasei America, Inc.

Plan Year. *Plan Year* means the 12-month period established by the Plan Sponsor for purposes of administering the Plan and maintaining its financial records. The Plan year for this Plan means the period of time between 12:00 A.M. January 1 and 11:59 P.M. December 31 of each calendar year.

Premium Payment. *Premium Payment* means the contribution for coverage under the Plan to be paid by the Plan Participant. The Premium Payment is in addition to copays, deductibles, and co-insurance amounts and does not apply toward any required deductible or out-of-pocket maximums under the Plan. The Premium Payment will include your required contribution for participation under the self-funded benefits (e.g., Health Plans and Flexible Spending Accounts) or your share of the premiums for any fully-insured benefits.

Qualified Medical Child Support Order (QMCSO). *Qualified Medical Child Support Order* means a domestic relations judgment or order mandated by a court which creates or recognizes the right of a Plan Participant's Child to receive benefits under the plan. Please see Appendix E for the Plan's QMCSO Procedures.

Qualified Status Change. *Qualified Status Change* means a limited series of events under which you may apply to the Plan Administrator to make mid-year changes to your benefit choices. The Plan Administrator, in its sole discretion, determines whether or not you will be permitted to make election changes in accordance with the terms of this Plan, the Cafeteria Plan and applicable law. You have **30 days** from the date of the Qualified Status Change to report the change to the Plan Administrator.

Retiree. *Retiree* means an Employee who retired from employment with the Employer prior to January 1, 2021, and satisfies each of the retiree eligibility conditions set forth in Section 4.3 above.

Severance Plan. *Severance Plan* means the severance plan identified in Appendix B.

Short-Term Disability Plan. *Short-Term Disability Plan* means the fully-insured short-term disability insurance benefit available to certain Employee Groups as identified in Appendix B. The Employer also sponsors other short-term disability benefits that are self-funded from the Employer's general assets for certain Employee Groups, which are considered payroll practices exempt from ERISA and are described in separate booklets or policies.

Spouse. *Spouse* means one individual of the same or opposite gender who is legally married to a Participant in jurisdictions, countries or tribal nations that authorize or recognize that legal marriage, regardless of where that Participant and individual reside. The Plan will treat a Participant and his or her Spouse as married for state and federal tax purposes.

The Plan, however, does not recognize common law marriages, even if common-law marriages are recognized under the laws of your state of domicile. The Plan also does not treat a domestic partner as an Eligible Family Member or as a Spouse (unless legally married), except as expressly provided otherwise in the Supplemental Plan Document for a fully-insured medical plan. The legal married status between you and your Spouse must have existed at the time that the expense was incurred for which reimbursement is claimed, but shall not include an individual who is legally divorced or separated from you under a decree of divorce, legal separation or of separate maintenance (regardless of any obligation for you to provide coverage for such individual). The Plan reserves the right to require documentation of your marital status at any time.

Supplemental Plan Document. The separate plan documents, including the Claims Administrator's certificates, contracts and/or booklets, collective bargaining agreements, employee benefits overview, the annual enrollment benefit guide, and other formal plan documents, that govern each of the underlying benefit programs that make up this Plan. These documents include the specific description of the actual covered and excluded benefits for each benefit option offered under the Plan, including benefit percentage, coinsurance, deductible, out of pocket maximum, benefit maximums and other limitations. The materials that comprise the Supplemental Plan Documents are provided separately, but are incorporated by reference and considered part of this Plan document. This Plan document wraps around each of these Supplemental Plan Documents and together they constitute the Legal Wrap Welfare Plan and Summary Plan Description document.

USERRA. *USERRA* means the Uniformed Services Employment and Re employment Rights Act of 1994, as amended, including regulatory and sub-regulatory guidance thereunder.

Vision Plan. *Vision Plan* means the vision benefit options identified in Appendix B.

APPENDIX A
PARTICIPATING EMPLOYERS[1]

Participating Employer Name	EIN
Asahi Kasei America, Inc. (Lead Plan Sponsor)	13-2698638
Asahi Kasei Plastics North America, Inc.	38-1842563
Asahi Kasei Asaclean Americas, Inc.	22-3449513
Asahi Kasei Bioprocess America, Inc.	26-3768762
Crystal IS, Inc.	33-1222464
AKM Semiconductor, Inc.	77-0404174
Asahi Kasei Plastic (America), Inc.	13-3498415
Daramic, LLC	57-1006869
Celgard, LLC	56-2169137
Polypore International, Inc.	57-1006871
Sage Automotive Interiors, Inc.	27-0266382
Asahi Kasei Advance America, Inc.	84-4062335
Veloxis Pharmaceuticals, Inc.	45-0552241
Bionique Testing Laboratories LLC	14-1734833
Bionova Scientific LLC	83-4701048

[1] This Appendix A has been updated as of January 1, 2023. The Plan Administrator may add or delete other Participating Employers without any formal Plan amendment or change to this Appendix. You should contact the Plan Administrator to inquire about any recent changes to this Appendix A.

APPENDIX B
CURRENT AVAILABLE BENEFITS, SOURCE OF FUNDING, CONTRIBUTION REQUIREMENTS AND TYPE AND NAME OF CLAIMS ADMINISTRATORS[2]

SEE THE APPENDIX B THAT APPLIES TO YOUR EMPLOYEE GROUP, WHICH INCLUDES:

1. Sage Employee Group

2. General Employee Group

[2] The Appendix B that applies to your Employee Group will set forth additional information on which benefits are offered to your Employee Group, any special eligibility or other rules that apply to your Employee Group and the Claims Administrators' contact information. The Plan Administrator updates the Appendix B that applies to your Employee Group frequently and may do so without a formal amendment to this Plan document. You should contact the Plan Administrator to inquire about any recent changes to such Appendix

APPENDIX C
EMPLOYER SHARED RESPONSIBILITY RULES UNDER CODE SECTION 4980H

C.1 Definitions. Throughout this Appendix, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined below and shall be used for the sole purposes of administering the Employer Shared Responsibility Rules. Any specialized term not defined below shall have the meaning ascribed to it under the Employer Shared Responsibility Rules.

(A) *ACA*. The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, and its related regulations, rules and guidance promulgated by governmental agencies.

(B) *Administrative Period*. An optional period, selected in the sole discretion of an Applicable Large Employer Member as set forth below, of no longer than 90 days beginning immediately following the end of the Initial or Standard Measurement Period and ending immediately before the start of the associated Stability Period (and also includes the period before a new employee's start date and the beginning of the initial measurement period), as further defined under and subject to Treasury Regulations §54.4980-1(a)(1).

(C) *Applicable Large Employer and Applicable Large Employer Member*. Applicable Large Employer and Applicable Large Employer Member have the meanings ascribed to them under Code Section 4980H and Treasury Regulations §54.4980-1(a)(4) & (5), and generally includes an employer, for that calendar year, that employed on average at least 50 Full-Time Employees (including full-time equivalent employees) during the preceding calendar year. For purposes of this Appendix, Applicable Large Employer Member shall mean Belle Tire Distributors, Inc. and each other related entity within the meaning of Code Section 414(b), (c), (m) or (o) who is participating under the Plan.

(D) *Employer Shared Responsibility Rules*. The ACA rules that potentially impose excise taxes on Applicable Large Employer Members as codified under Code Section §4980H, Treasury Regulations §54.4980H-1, et. seq., and any other related regulations, rules and guidance promulgated by federal governmental agencies.

(E) *Full-Time Employee*. A common-law employee of an Applicable Large Employer Member who is employed an average of at least 30 Hours of Service a week (using a 130 Hours of Service in a calendar month as the monthly equivalent of 30 Hours of Service a week) for that Applicable Large Employer Member, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(21).

(F) *Health Insurance Marketplace or Marketplace*. A government resource where individuals, families, and small businesses can: learn about their health coverage options; compare Qualified Health Plans based on costs, benefits, and other important features; choose a Qualified Health Plan; and enroll in coverage. The Marketplace encourages competition among private Qualified Health Plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government (for more information, visit https://www.healthcare.gov/marketplace-in-your-state/).

(G) *Hours of Service*. Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Applicable Large Employer and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b–2(a)). Notwithstanding anything to the contrary, Hours of Service shall not include excluded hours (e.g. for hours by bona-fide volunteers, for work-study program or outside the U.S.) in accordance with the Employer Shared Responsibility Rules.

(H) *Initial Measurement Period*. A period of at least three (3) but not more than twelve (12) consecutive months that is used by an Applicable Large Employer Member, at its sole election as reflected below or other ACA policies, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(25).

(I) *Look-back Measurement Method*. One of the two available methods of determining an Employee's status as a Full-Time Employee or Non-Full-Time Employee for the sole purpose of the Employer Shared

Responsibility Rules explained in this Appendix. The Look-Back Measurement Method involves identifying an Employee's Hours of Service over an Initial or Standard Measurement Period that is at least three consecutive months but not more than 12 consecutive months in order to determine his or her Full-Time or Non-Full-Time Employee status during a following Stability Period.

(J) *MEC*. For purposes of the Employer Shared Responsibility Rules, Minimum Essential Coverage within the meaning ascribed under Code Section 5000A(f) and related Treasury Regulations. Under the terms of this Plan document, MEC only shall include the Medical Program sponsored by the Employer (whether fully-insured or self-funded), but shall not include excepted benefits described in Section 2791(c)(1), (c)(2), (c)(3) or (c)(4) of the Public Health Service Act (e.g. excepted dental, vision, or Health Care Spending Account coverage).

(K) *Monthly Measurement Method*. One of the two available methods of determining an Employee's status as a Full-Time Employee or Non-Full-Time Employee for the sole purpose of the Employer Shared Responsibility Rules explained in this Appendix. The Monthly Measurement Method involves a month-to-month analysis of Hours of Service credited during a particular calendar month to determine Full-Time or Non-Full-Time Employee status.

(L) *New Employee*. An employee who has been employed by the Applicable Large Employer for less than one complete Standard Measurement Period.

(M) *Non-Full-Time Employee*. A common-law employee of an Applicable Large Employer Member who is employed an average of fewer than 30 Hours of Service a week (using a 130 Hours of Service in a calendar month as the monthly equivalent of 30 Hours of Service a week) for that Applicable Large Employer Member.

(N) *Ongoing Employee*. A common-law employee of an Applicable Large Employer Member who has been employed by the employer for at least one complete Standard Measurement Period, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(31).

(O) *Part-Time Employee*. A new common-law employee of an Applicable Large Employer Member who is employed less than one complete Standard Measurement Period for whom that employer reasonably expects to work on average less than 30 Hours of Service a week with that Applicable Large Employer Member, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(32).

(P) *Permissible Employee Categories*. The categories of employees recognized under the Employer Shared Responsibility Rules for which an Applicable Large Employer Member may elect to use different methods for determining full-time status and/or may use different periods within the Look-Back Measurement Method. The Permissible Employee Categories include only:

(1) Collectively bargained employees and non-collectively bargained employees;

(2) Each group of collectively bargained employees covered by separate collectively bargained employees;

(3) Salaried employees and hourly employees; and

(4) Employees whose primary places of employment are in different States.

(Q) *Qualified Health Plan*. An insurance plan created under the ACA that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

(R) *Seasonal Employee*. A common law employee of an Applicable Large Employer Member who is hired into a position for which the customary annual employment period is six months or less with the period beginning each calendar year in approximately the same part of the year, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(38).

(S) *Stability Period*. A period that immediately follows the Initial or Standard Measurement Period (and any Administrative Period) as selected by an Applicable Large Employer Member, at its sole discretion as

reflected below or other ACA policies, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(45).

(T) *Standard Measurement Period*. A period of at least three (3) but not more than twelve (12) consecutive months that is used by an Applicable Large Employer Member, at its sole election as reflected below, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(46).

(U) *Start Date*. The first day on which an employee is required to be credited with an Hour of Service with the Applicable Large Employer Member.

(V) *Variable Hour Employee*. A common law employee of the Applicable Large Employer Member for whom the employer cannot reasonably expect to be employed an average of at least 30 hours or service a week during the Initial Measurement Period because such employee's hours are variable or otherwise uncertain, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(49).

C.2 Assessment of the Excise Tax. Beginning on January 1, 2015, the Applicable Large Employer Members may be subject to an excise tax under the Employer Shared Responsibility Rules under the circumstances described in subparagraphs (a) or (b) below.

(A) *Section 4980H(a) Penalty*. An Applicable Employer Member fails to offer substantially all Full-Time Employees (and their dependent-children) the opportunity to enroll in MEC and any Full-Time Employee is certified to such Applicable Large Employer Member as having received an applicable premium tax credit or cost-sharing reduction for purchasing a Qualified Health Plan through Marketplace.

(B) *Section 4980H(b) Penalty*. An Applicable Employer Member offers substantially all of its Full-Time Employees (and their dependent-children) the opportunity to enroll in MEC and one or more Full-Time Employees is certified to such Applicable Large Employer Member as having received an applicable premium tax credit or cost-sharing reduction for purchasing a Qualified Health Plan through Marketplace.

(C) *Premium Tax Credit or Cost-Sharing Reduction for a Qualified Health Plan*. A Full-Time Employee generally would be eligible to receive an applicable premium tax credit or cost-sharing reduction for the purchase of a Qualified Health Plan through the Marketplace only if he or she (i) is not offered MEC or is offered MEC but it is deemed unaffordable or does not provide minimum value, (ii) has household income of 100% but less than 400% of federal poverty level and (iii) is not eligible for Medicare or Medicaid or similar governmental program. If an Applicable Large Employer Member does not have any Full-Time Employee who receives a premium tax credit or cost-sharing reduction for a Qualified Health Plan, then there would be no excise tax assessment under the Employer Shared Responsibility Rules for that Applicable Large Employer Member.

C.3 Amount of the Excise Tax. Both the section 4980H(a) or (b) penalty is assessed on a calendar monthly basis and an Applicable Large Employer Member can only be liable for either the section 4980H (a) or (b) penalty for any one calendar month, not both. For an Applicable Large Employer that has two or more members/entities under common control (within the meaning of Code Section 414(b), (c), or (m)), the section 4980H penalty is determined and assessed separately against each Applicable Large Employer Member (i.e. when the penalty is assessed, it will be based on the common-law employees employed directly by that Applicable Large Employer Member and will not include the employees of other Applicable Large Employer Members under common control).

(A) *4980H(a) Penalty Amount*. The section 4980H(a) penalty equals $166.67 (as adjusted by the IRS for inflation; e.g., $214.17 for 2020) multiplied by the number of Full-Time Employees of the Applicable Large Employer Member for the calendar month of assessment. In counting Full-Time Employees for a calendar month, the Applicable Large Employer Member can exclude up to its allocable share of 30 Full-Time Employees. An Applicable Large Employer Member's allocable share is equal to 30 allocated ratably among all members of the Applicable Large Employer on the basis of the number of Full-Time Employees employed by each member during that calendar month rounded to the next highest whole number. Solely with respect to the 2015 Plan Year and for an Applicable Large Employer with 100 or more Full-Time Employees plus full-time equivalent employees during the 2014 calendar year, the 30 threshold is increased to 80).

(B) *4980H(b) Penalty Amount.* The section 4980H(b) penalty equals $250 (as adjusted by the IRS for inflation; e.g., $321.66 for 2020) multiplied by the number of Full-Time Employees who actually receive

premium tax credits or cost-sharing reductions for the Qualified Health Plan he or she purchases from the Marketplace; provided, however, that the aggregate amount of the section 4980H(b) penalty shall not exceed the amount of the section 4980H(a) penalty multiplied by the Full-Time Employees for that calendar month (reduced by the allocable share of the 30 threshold).

C.4 Determination of Full-Time Employee. Each of the Applicable Large Employer Members participating in the Plan have elected to use the Look-Back Measurement Method and apply the rules set forth below uniformly to all Permissible Employee Categories.

(A) *Standard Measurement Period*. The following rules apply to the Standard Measurement Period (provided, however, that the Plan Administrator retains the discretion to change the measurement periods from Plan Year to Plan Year as reflected in its ACA tracking system, which measurement periods shall control and be incorporated by reference to amend the provisions set forth below):

(1) The Standard Measurement Period for Ongoing Employees shall be November 1 through the following October 31. At the discretion of the Employer, the Standard Measurement Period may be adjusted for the special payroll period rule set forth in Treasury Regulations §54.4980H-3(d)(1)(ii).

(2) The Standard Measurement Period shall be followed by an Administrative Period from November 1 to December 31 (i.e. the period that begins immediately after the Standard Measurement Period closes and that ends immediately before the start of the associated Stability Period described in subparagraph (3) below).

(3) The Stability Period for an Ongoing Employee who is determined to be a Full-Time Employee during the preceding Standard Measurement Period shall be January 1 – December 31.

(4) An Ongoing Employee who is determined to be a Full-Time Employee during a Standard Measurement Period shall be treated as a Full-Time Employee during the associated Stability Period, subject to the rules set forth under Treasury Regulations §54.4980H-3. The Applicable Large Employer Member shall notify the affected Ongoing Employee during the associated Administrative Period of his or her status as a Full-Time Employee during the Stability Period and his or her eligibility for Medical Program coverage during the associated Stability Period, provided he or she is still employed as of the first day of the Stability Period.

(5) An Ongoing Employee who is determined to be a Non-Full-Time Employee during the Standard Measurement Period shall be treated as a Non-Full-Time Employee and shall not be offered coverage during the associated Stability Period that follows the associated Standard Measurement Period, subject to the rules set forth under Treasury Regulations §54.4980H-3 or as otherwise provided in the Plan.

(6) An Ongoing Employee's status as a Full-Time or a Non-Full-Time Employee during the Standard Measurement Period results in same status during the subsequent Stability Period, regardless of the number of Hours of Service completed or a change in employment position during such associated Stability Period.

(B) *Initial Measurement Period*. The following rules apply to the Initial Measurement Period:

(1) The Initial Measurement Period for new Variable Hour, Seasonal or Part-Time Employees shall be 12 months. At the discretion of the Employer, the Initial Measurement Period may be adjusted for the special payroll period rule set forth in Treasury Regulations §54.4980H-3(d)(3)(ii).

(2) The Initial Measurement Period shall begin on the first day of the month following the new Variable Hour, Seasonal or Part-Time Employee's Start Date.

(3) The Initial Measurement Period shall be followed by an Administrative Period that begins on the first calendar day following the close of the Initial Measurement Period and ends on the last day of the first calendar month beginning on or after the New Employee's anniversary of his or her Start Date. In no event will the Administrative Period for the Initial Measurement Period exceed a total of 90 days, that includes all periods between a New Variable Hour, Part-Time or Seasonal Employee's Start Date and when such employee is first offered coverage, but excluding the Initial Measurement Period itself. Additionally, the combined length of the Initial Measurement Period and the associated Administrative

Period shall not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the such Employee's Start Date.

(4) The Stability Period for a new Variable Hour, Seasonal or Part-Time Employee who is determined to be a Full-Time Employee during the preceding Initial Measurement Period shall be 12 months.

(5) If a new Variable Hour, Seasonal or Part-Time Employee is determined to be a Full-Time Employee during the Initial Measurement Period, such Employee shall be treated as a Full-Time Employee and will be offered Medical Program coverage during the initial Stability Period, provided he or she is still employed as of the first day of the Stability Period.

(6) The Stability Period for a new Variable Hour, Seasonal or Part-Time Employee who is determined to be a Non-Full-Time Employee during the preceding Initial Measurement Period shall be 12 months; provided, however, that such Stability Period (i) shall begin immediately following the associated Initial Measurement Period (and the associated Administrative Period), (ii) shall not be more than one month longer than the Initial Measurement Period identified above, and (iii) shall not exceed the remainder of the first entire Standard Measurement Period (plus any Administrative Period) identified herein for which such employee has been employed.

(7) A new Variable Hour, Seasonal or Part-Time Employee who is determined to be a Non-Full-Time Employee during the Initial Measurement Period shall be treated as a Non-Full-Time Employee and shall not be offered Medical Program coverage during the initial Stability Period.

(8) If, as of Employee's Start Date, the Employee cannot be reasonably classified as a Variable Hour, Seasonal or Part-Time Employee (e.g. he or she is reasonably expected to work on average 30 or more Hours of Service per week and is not a Seasonal Employee), the Monthly Measurement Method (as set forth under Treasury Regulations Section 54.49080H-3(c)) must be used for this Employee until he or she becomes an Ongoing Employee. In other words, an Initial Measurement Period cannot apply to such a New Employee, but the Standard Measurement Period can apply to him or her once they become an Ongoing Employee by being employed for a complete Standard Measurement Period.

(9) If a New Employee changes employment status during the Initial Measurement Period into a position where he or she is reasonably expected to work on average 30 or more hours/week, such Employee will be treated as a Full-Time Employee as of the first day of the fourth calendar month following change in status (or if earlier, the end of the Initial Measurement Period and its associated Administrative Period).

(10) During each Annual or Special Enrollment Period, the Employer shall notify Ongoing Employees and New Variable Hour, Seasonal and Part-Time Employees of their status as Full-Time or Non-Full-Time Employees for the Stability Period following the Initial and Standard Measurement Periods and of such Employees' eligible or non-eligible status for an offer of coverage under the Medical Program.

C.5 Rules Regarding Employees Rehired or Resuming Service After a Period of no Credited Hours of Service. Notwithstanding the main text of the Plan Document, the following additional rules apply under this Appendix:

(A) *Monthly Measurement Method*. If the Monthly Measurement Method applies to an Employee, the following rules apply:

(1) If an Employee resumes providing services for the Employer after of period during which the Employee was not credited with any Hours of Service ("break in service") of at least thirteen (13) consecutive weeks, such Employee will be treated as a newly hired Employee. If the Employee's break in service is for a period of at least four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period is longer than the preceding employment period, the Employee also will be treated as a newly hired Employee. As a newly hired Employee, the non-assessment period shall apply as set forth under Treasury Regulations 54.4980H-3(c)(2).

(2) If the Employee's break in service is either (i) less than four (4) consecutive weeks, or (ii) is greater than four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period was not longer than the preceding employment period, the Employee shall be treated as

a continuing Employee and the non-assessment period shall not apply to him or her (i.e. if rehired as a Full-Time Employee, Medical Program coverage should be made available no later than the first day of the calendar month following resumption of services to avoid a potential assessment of the excise tax for that calendar month).

(B) *Look-Back Measurement Period*. If the Look-Back Measurement Method applies to an Employee, the following rules shall apply:

(1) An Employee who resumes providing services for the Employer after a period during which the Employee was not credited with any Hours of Service ("break in service") of at least thirteen (13) consecutive weeks, the Employee will be treated as a newly hired Employee. An Employee whose break in service is for a period of at least four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period was longer than the preceding employment period, also shall be treated as a newly hired Employee. In this event, a new Initial Measurement Period will apply if rehired as a Variable Hour, Part-Time or Seasonal Employee.

(2) An Employee whose break in service is either (i) less than four consecutive weeks or (ii) greater than four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period was not longer than the preceding employment period, shall, upon resumption of services, be treated as a continuing Employee. Such a continuing Employee shall retain, upon resumption of services, the status that Employee had with respect to the application of any Stability Period. If the continuing Employee was considered a Full-Time Employee for the Stability Period and eligible for Medical Program coverage, then he or she, upon resumption of services, will be eligible for Medical Program coverage as of his or her reemployment commencement date or, if later, as soon as administratively practicable (i.e. the first day of the calendar month following resumption of services); unless such continuing Full-Time Employee previously declined the Employer's offer of coverage for that Stability Period. If the continuing Employee is not considered a Full-Time Employee for the Stability Period or previously declined coverage, then no offer of coverage under the Medical Program will be made for the remainder of that Stability Period.

(3) For a continuing Employee with an special unpaid leave (i.e. FMLA, USERRA or jury duty leaves), such Employee's average Hours of Service during the measurement period generally shall be determined by computing the average hours, after excluding the special unpaid leave period during that measurement period and by using the average as the average for the entire measurement period (or adopt any other alternative permitted under Treasury Regulation 54.4980H-3(d)(6)(i)(B).

C.6 Incorporation by Reference of the Employer Shared Responsibility Rules. This Appendix, along with any other policies and procedures established by each Applicable Large Employer Member participating under the Employer's Medical Program, shall indicate, if necessary, the measurement methods adopted and any other essential information for each eligible classifications of Employees implemented by the Applicable Large Employer Member for purposes of the Employer Shared Responsibilities Rules. Notwithstanding anything to the contrary, the Employer Shared Responsibility Rules are incorporated herein by reference and shall control and dictate how the measurement methods and determination rules for Full-Time Employee status shall apply to the Applicable Large Employer Member. Each Plan Year, the Employer retains the discretion to adjust the Measurement Periods, Administrative Periods and Stability Periods without a formal amendment to this Appendix F. If the Employer Shared Responsibility Rules are repealed, this Appendix F and references to it in the Plan document shall automatically be void and shall no longer control or affect the eligibility provisions under the Plan document on and after the effective date of such repeal of those rules.

APPENDIX D
HIPAA NOTICE OF PRIVACY PRACTICES
UNDER THE ASAHI KASEI HEALTH PLANS

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Introduction

Asahi Kasei America, Inc. and the Participating Employers, if any, (in the aggregate, the "Employer") sponsor and maintain group health plans, including a Medical Plan (which provides medical and prescription benefits), Dental Plan, Vision Plan, Employee Assistance Program and Health Care Spending Account Plan (in the aggregate referred to as the "Plan"). The Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA") generally restrict the ability to use and disclose certain health or medical information about you that is created or received by the Plan with respect to these health care benefit programs or by the Employer in connection with such health care benefit programs.

The Plan is required to provide this Notice of Privacy Practice (the "Notice") to you pursuant to HIPAA. This Notice describes how medical information about you may be used or disclosed by the Plan or by others that assist in the administration of Plan claims. This Notice also describes your legal rights regarding your medical information held by the Plan. References to the Plan throughout this Notice taking certain actions also shall mean the Employer, as plan sponsor of the Plan. For any of the group health benefits under the Plan that are fully-insured, an additional notice regarding the insurance company's privacy practices is required by law to be sent directly to you by the insurance company. Thus, in some circumstances you may receive more than one notice regarding privacy practices regarding your group health benefits under the Plan.

Privacy Officer/Contact Person

If you have any questions about this Notice or your privacy rights, please contact the HIPAA Contact Person, Asahi Kasei Benefits, 13800 South Lake Drive, Charlotte, NC 28273, (704) 587-8882 (asahi-benefits@ak-america.com).

In many instances, because your information is maintained by independent Third Party Administrators engaged by the Plan, rather than the Plan or the Employer itself, you may be referred to the appropriate Third Party Administrator for assistance with your questions or request.

Protected Health Information

The HIPAA Privacy Rules protect only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan, that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Effective Date

This Notice is effective January 1, 2023.

Our Pledge and Responsibilities Regarding PHI

We understand that PHI about you and your health is personal and the Plan is committed to protecting PHI. The Plan is required by law to satisfy the following responsibilities with respect to any PHI created or received by the Plan:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

How the Plan May Use and Disclose Medical Information About You

Under law, the Plan may use or disclose your PHI under certain circumstances without your permission. The following categories describe different ways that the Plan may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories. The Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request. The "minimum necessary" standard will not apply, however, to certain disclosures, such as disclosures of your PHI to you.

For Treatment. The Plan may use or disclose your PHI to facilitate medical treatment or services by providers. The Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel, who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contra indicate a pending prescription or the Plan may disclose to your specialist the name of your regular physician so that the specialist may request your medical records from your regular physician.

For Payment. The Plan may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary or to determine whether the Plan will cover the treatment. The Plan also may share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

The Plan may release PHI about you that is directly relevant to the involvement of a family member, close personal friend or other person in your medical care or payment for your medical care, unless you tell us not to release such information to such person.

For Health Care Operations. The Plan may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

However, the Plan may not use or disclose any PHI that is genetic information for underwriting purposes.

To Plan Sponsor (i.e. the Employer). For the purpose of administering the Plan, PHI may be disclosed to certain authorized employees of the Employer. However, those authorized employees will use or disclose that PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA (unless you have authorized further uses or disclosures beyond those administrative functions. For example, the Plan may disclose to authorized employees certain enrollment information, summary health information for obtaining premium bids or other PHI necessary to perform Plan administrative, including, but not limited to, evaluating potential new insurers or service providers to the Plan, assisting participants with claims disputes or questions, coordinating COBRA continuation coverage, etc.

Your PHI cannot be used for employment related purposes without your specific, written authorization.

To Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. To perform these functions or provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization, management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

As Required by Law. The Plan will disclose PHI about you when required to do so by federal, state or local law. For example, the Plan may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose PHI about you in a proceeding regarding the licensure of a physician.

Personal Representatives. The Plan will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney in fact, etc., as long as you provide the Plan with a written

notice/authorization and any supporting documents (e.g. durable power of health care attorney). Note that under HIPAA privacy rule, the Plan does not have to disclose PHI to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's Spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's Spouse and other family members and information on the denial of any Plan benefits to the employee's Spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below "Your Rights"), and the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

In limited circumstances, the Plan also may disclose PHI to your friends or family members if: (1) you are present and do not object to the disclosure, or (2) you are not present and the Plan determines that the disclosure would be in your best interest.

Special Situations

Although less likely, the following categories describe other possible ways that the Plan may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release PHI about you as required by military command authorities. The Plan also may release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release PHI about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose PHI about you for public health activities. The activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- About criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Disclosures

The following is a description of disclosures of your PHI the Plan is required to make:

Government Audits. The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy rule.

Disclosures to You. When you request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan also is required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI was not disclosed pursuant to your individual authorization.

Authorizations

Other than disclosures to directly to you, the Plan will ask you for your written authorization before using or disclosing your PHI for any purpose not described above, including uses and disclosures of PHI for marketing purposes, disclosures that would constitute a sale of PHI, and most uses and disclosures of psychotherapy notes. You may revoke written authorization at any time, as long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights regarding PHI that the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer/Contact Person listed above. If you request a copy of the information, you may be charged a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

You generally shall have the right, upon written request, to obtain from the Plan an electronic copy of PHI that is maintained electronically in one or more Designated Record Sets, and, if you choose, to direct the Plan to transmit such copy to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific. The Plan will provide the requested PHI in the format requested by you, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the Plan and you. You also may direct the Plan, in a written statement signed by you, to transmit a paper or electronic copy of your PHI to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific (e.g. clearly identifies the designated person and where to send a copy of your PHI).

The Plan may deny your request to inspect and copy PHI under very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Privacy Officer/Contact Person listed above.

Right to Amend. If you believe that PHI the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer/Contact Person listed above. In addition, you must provide the reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is already accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosure of the disputed information will include your statement. File this statement with the Privacy Officer/Contact Person listed above.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting generally will not include (1) disclosures made for purposes of treatment, payment or health care operations, (2) disclosures made to you, (3) disclosures made pursuant to your authorization, (4) disclosures made to friends or family in your presence or because of an emergency, (5) disclosures for national security purposes, and (6) disclosures incidental to otherwise permissible disclosures. However, to the extent required under HITECH, certain disclosures to carry out treatment, payment or health care operations which are maintained in electronic health records may need to be included in the accounting of disclosures beginning on the effective date set forth in HITECH (please call the Privacy Officer/Contact Person if you would like additional information regarding such accounting rights under the applicable guidance).

To request this list of accounting of disclosures, you must submit your request, in writing, to the Privacy Officer/Contact Person listed above. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

The Plan generally is not required to agree to your request. Note that you have the right to request that your health care provider not disclose certain PHI to this Plan in the event that the PHI pertains solely to health care items or services that you pay for out of pocket and in full.

To request restrictions, you must make your request in writing to the Privacy Officer/Contact Person listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your Spouse.

The Plan may terminate a restriction that it previously agreed to with respect to your PHI provided that the Plan informs you that it is terminating its agreement to the restriction and such termination is not effective for PHI that is described in the first two paragraphs of this section and only effective with respect to PHI created or received after you have been informed of such termination.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer/Contact Person listed above. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach. You generally have the right to be notified in the event that we discover, or a Business Associate discovers, a breach of unsecured PHI, unless there is a low probability that the PHI has been compromised. If it is determined from the Plan's risk assessment that a breach has occurred, you will be notified

without unreasonable delay and no later than 60 days after discovery of the breach. The notification will include information about what happened and what may be done to mitigate any harm.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact the Privacy Officer/Contact Person listed above.

Changes to This Notice

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that the Plan maintains, as allowed or required by law. The Plan reserves the right to make the revised or changed Notice effective for PHI the Plan already has about you as well as any information the Plan receives in the future. If the Plan makes any material change to this Notice, you will be provided with a copy of a revised Notice of Privacy Practices either by mail or electronically.

Complaints

If you have questions or comments about the Plan's Notice of Privacy Practices or the Plan's privacy policies and procedures, please contact the Plan's HIPAA Privacy Officer at the address or phone number listed above. If you would like to file a complaint with the Privacy Officer about the Plan's use or disclosure of your PHI or the Plan's privacy policies and procedures (including its breach notification policies and procedures), please submit your complaint in writing to the Privacy Officer at the address listed above.

You also may file a complaint the Office of Civil Rights. Your complaint must be submitted within 180 days of when you knew or should have known of the issue, unless this deadline is waived by the Office for Civil Rights. A complaint to the Office of Civil Rights should be sent to Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. - Suite 240, Chicago, IL 60601, (312) 886-2359; (312) 353-5693 (TDD), (312) 886-1807 (fax). You also may visit OCR's website at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/ for more information.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Plan or the Office of Civil Rights.

APPENDIX E
PROCEDURES FOR
QUALIFIED MEDICAL CHILD SUPPORT ORDERS

E.1 Procedure. Except in the case of a National Medical Support Notice as described in Section E.5, if the Plan receives a Medical Child Support Order (as hereinafter defined), the following procedures shall apply with respect to the Health Plans:

(a) The Plan Administrator will promptly notify the Participant and each Alternate Recipient (as hereinafter defined) of the Plan's receipt of such order, of the Plan's procedures for determining whether a Medical Child Support Order is a Qualified Medical Child Support Order, and of the right of the Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(b) Within a reasonable period after receipt of such order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination. In making such determination, the Plan Administrator may, in its sole discretion, apply to a court of competent jurisdiction for its determination.

(c) Any determination of the Plan Administrator shall be subject to the Claim and Claims Review Procedures under the Plan.

E.2 Effect of Determination. If the Plan Administrator determines that a Medical Child Support Order is a Qualified Medical Child Support Order or a National Medical Support Notice is deemed to be a Qualified Medical Child Support Order as described in Section E.5, then:

(a) The Alternate Recipient shall be considered a Dependent Child of the Participant under the Plan.

(b) Any payment for benefits in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof.

(c) The Alternate Recipient shall be considered a Participant of the Plan for purposes of the reporting and disclosure requirements of Part 1 of ERISA.

(d) Except as provided in Section E.5, coverage of the Alternate Recipient shall be effective as of the latest of:

(1) the first day of the month specified in the Order;

(2) the first day of the month following the determination by the Plan Administrator; or

(3) the earlier of (A) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (B) the

effective date of a court or administrative order requiring the Employer to withhold from the Participant's compensation, the Participant's share, if any, of premiums for health coverage and to pay such share of premiums to the Plan.

(e) If the Plan and any fiduciary under the Plan acts in accordance with the provisions of these procedures in treating a medical child support order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

E.3 Special Eligibility Rules for Qualified Medical Child Support Orders. Solely for purposes of determining if an Order is a Qualified Medical Child Support Order under these procedures:

(a) The definition of Dependent Children in the Plan shall not be deemed to exclude from health coverage under the Plan:

(1) A Child born out of wedlock;

(2) A Child not claimed as a dependent on the Participant's Federal income tax return; or

(3) A Child that does not reside with the Participant;

but only if a Qualified Medical Child Support Order is in effect for such Child which requires the Participant, the other parent or a State Agency to pay 100% of the cost of health coverage for such child, through withholding from the Participant's compensation or otherwise.

(b) If any Qualified Medical Child Support Order requires a participant to provide health coverage for an Alternate Recipient:

(1) Such Participant may enroll such Alternate Recipient for family coverage pursuant to the procedures under the Plan.

(2) If the Participant is enrolled but fails to make application to obtain coverage of such Alternate Recipient, such Alternate Recipient shall be enrolled in family coverage upon application by the Alternate Recipient's other parent or by the State Agency administering the program under Subchapter XIX or Part D of Subchapter IV of Chapter 17 of Title XIX of the Social Security Act (42 U.S.C.A. Section 1396 et seq.) (the "Social Security Act").

E.4 Termination of Coverage. Except to the extent required by law (e.g. COBRA), coverage for an Alternate Recipient will terminate:

(a) When the Qualified Medical Child Support Order is no longer in effect;

(b) When the Alternate Recipient's age exceeds the maximum age under which a Dependent Child may participate under the Plan;

(c) When the Plan Administrator is provided written evidence that the Alternate Recipient is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment; or

(d) The Plan Administrator has eliminated family health coverage for all of its employees.

E.5 National Medical Support Notice.

(a) If the Plan Administrator receives an appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 (the "Child Support Act") with respect to a Child of a noncustodial parent, and the Notice meets the requirements of Section E.6(d)(2) hereunder, the Notice shall be deemed to be a Qualified Medical Child Support Order in the case of such Child.

(b) In any case in which an appropriately completed National Medical Support Notice is issued with respect to a Child of a Participant who is such Child's noncustodial parent, and the Notice is deemed under subsection (a) to be a Qualified Medical Child Support Order, the Plan Administrator, within 40 business days after the date of the Notice, shall:

(1) Notify the State agency issuing the Notice with respect to such Child whether coverage of the Child is available under the terms of the Plan and, if so, whether such Child is covered under the 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) to effectuate the coverage; and

(2) 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 shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such notice.

(d) A noncustodial parent shall be liable to the Plan for employee contributions required under the Plan for enrollment of the Child, unless such noncustodial parent properly contests such enforcement based on a mistake of fact.

E.6 Definitions. For purposes of these procedures, the following definitions shall be applicable:

(a) "Alternate Recipient" means any Child of an Eligible Employee of the Employer who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to such Employee.

(b) "Child" includes any child adopted by or placed for adoption with the Participant.

(c) "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an authorized government agency which:

(1) provides for child support with respect to a Child of a Participant under the Plan or provides for health benefit coverage to such a Child, is made

pursuant to a state domestic relations law (including community property law), and relates to group health benefits under the Plan, or

(2) enforces a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act with respect to the group health benefit under the Plan.

(d) "Qualified Medical Child Support Order" means a Medical Child Support Order which:

(1) creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits for which a Participant or Beneficiary is eligible under the group health provisions of the Plan, and

(2) meets the following requirements:

(A) clearly specifies the name and last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order,

(B) clearly specifies 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,

(C) clearly specifies the period to which such order applies,

(D) clearly specifies each plan to which such order applies, and

(E) 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 1396g of Title XIX of the Social Security Act.

APPENDIX F

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840 TTY: (617) 886-8102	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**

Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX G

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the Medical Plan's network.

When balance billing isn't allowed, you also have the following protections:

(A) You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

(B) Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Helpdesk at 1-800-985-3059, which is a joint taskforce of the Department of Labor, Department of Treasury and Department of Health and Human Services which are responsible for enforcing the federal surprise billing protection laws.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.