#### THE AVAYA INC. HEALTH AND WELFARE BENEFITS PLAN

Effective as of January 1, 2020

(Except as Otherwise Provided)

[Plan Number 551]

[Notice: The Avaya Inc. Health and Welfare Benefits Plan ("Plan") consists of this document, attachments, and separate documents and summary plan descriptions which describe the specific benefits provided by the Plan, as amended from to time to time. These documents are fully incorporated into this Plan document by this reference. These separate benefit program documents should be reviewed in conjunction with this Plan document. If there is an irreconcilable conflict between the specific terms of the program document and the terms of this Plan document, the Plan shall control (to the extent not contrary to any applicable law); except that any terms exclusively applicable to a benefit program shall be set forth in the applicable program document. However, if a benefit under the Plan is insured and there is an irreconcilable conflict between the specific terms of the insurance contract and the terms of the Plan document, the insurance contract will govern to the extent not contrary to any applicable law.]

i

# **TABLE OF CONTENTS**

ARTICLE I DEF	INITIONS	1
1.1	Definitions	1
ARTICLE II INT	RODUCTION	4
2.1	Introduction	
2.2	Purpose of Document	4
ARTICLE III ELI	GIBILITY AND PARTICIPATION REQUIREMENTS	5
3.1	Eligibility and Participation	
3.2	Qualified Medical Child Support Orders	
3.3	Enrollment	
3.4	Special Enrollment Rights	10
3.5	Termination of Participation	10
3.6	COBRA Continuation Coverage	11
ARTICLE IV PL	AN BENEFITS	12
4.1	Benefits Provided	
4.2	Preexisting Conditions and Other Exclusions	
4.3	Funding	
4.4	Right to Recover Benefit Overpayments and Other Erroneous	
	Payments	12
4.5	Participant's Responsibilities	
4.6	Right to Information and Fraudulent Claims	
ARTICLE V PLA	AN ADMINISTRATION	14
5.1	Plan Administration	14
5.2	HIPAA Privacy Rules	
5.3	HIPAA Portability Rules	
The Pla	an shall comply with the requirements of Code section 9801 et. seq.	
	including the requirement to cover children until the attainment of	
	age 26, if the Plan makes dependent coverage of children available.	
	The Plan Administrator shall only provide a certificate of creditable	
	coverage to the extent the underlying insurance constitutes a group	
	health plan as defined in Treas. Reg. section 54.9801-2	17
ARTICLE VI		18
CAEETEDIA DI	AN	10
6.1	Cafeteria Plan	
6.2	Participation	
6.3	Transfers	
6.4	Termination and Rehires	
6.5	Procedures for Enrollment	
0.3	Procedures for enrollment	19

6.6	Premium Conversion Accounts	. 19
6.7	Health Care Flexible Spending Accounts	. 20
6.8	Dependent Care Flexible Spending Accounts	. 21
6.9	Forfeitures/Transfers	. 22
6.10	Elections	. 22
6.11	Revocation of Elections	. 24
6.12	Nondiscrimination	. 29
6.13	Limitations on Contributions	. 30
6.14	Procedures for Reimbursements	. 30
ARTICLE VII DEN	IIAL OR LOSS OF BENEFITS	. 30
7.1	Denial or Loss of Benefits	. 30
7.2	Other Circumstances	. 30
ARTICLE VIII AM	IENDMENT OR TERMINATION OF THE PLAN	. 32
8.1	Amendment	. 32
8.2	Termination	. 32
ARTICLE IX CLAI	MS PROCEDURES	. 33
9.1	Benefit Claim	. 33
9.2	Appealing a Denied Claim	. 33
9.3	Important Appeal Deadlines	. 33
ARTICLE X GENE	RAL INFORMATION ABOUT THE PLAN	. 34
10.1	Limitation of Rights	. 34
10.2	Compliance With State and Federal Mandates	. 34
10.3	No Assignment	. 34
10.4	Severability	. 35
10.5	Insured Benefits	. 35
10.6	No Guarantee of Tax Consequences	. 35
10.7	Headings	. 35
10.8	Gender and Number	. 35
ATTACHMENT S	TATEMENT OF ERISA RIGHTS	. 36

#### **PREAMBLE**

Avaya Inc. (the "Company") maintains The Avaya Inc. Health and Welfare Benefits Plan (the "Plan") for eligible employees and their dependents.

The Plan is intended to be a welfare plan as defined in section 2510.3-1 of the Department of Labor Regulations and to qualify as a cafeteria plan, a medical care reimbursement plan, and a dependent care assistance plan under Code Sections 125, 105(b) and 129. The Plan consolidates the following welfare plan benefits: group medical, dental, vision, life, long-term disability, sickness and accident disability, flexible spending accounts, and group legal services (the "Welfare Plans").

The Plan document, the group insurance policies or contracts and benefit program descriptions for the Welfare Plans are intended to constitute one single plan under ERISA and the Internal Revenue Code (the "Code") for all purposes including the requirement of a written plan document and for all reporting and disclosure requirements. Nothing in this Plan, however, will subject any benefit program to ERISA if the benefit program would not otherwise be covered by ERISA.

The Plan is a single legal entity that is a covered entity whose business activities include both covered and non-covered functions. For purposes of complying with HIPAA's privacy and other administrative simplification requirements, the Plan is designated as a "hybrid entity" as defined in 45 C.F.R. Section 164.103. Accordingly, the Plan designates the medical, dental, vision, and employee assistance (to the extent it provides any medical benefits) programs as health care components in accordance with 45 C.F.R. Section 164.105(a)(2)(iii)(C).

The Plan was originally effective January 1, 2007. The Company hereby amends and restates the Plan as stated herein, effective as of January 1, 2020 (except as otherwise provided herein), to incorporate all effective amendments to the Plan since the last amendment and restatement and to make certain other changes.

The terms and provisions of the Plan as set forth in this instrument, along with any collective bargaining agreement(s) covering the employment of the individuals eligible to participate in the Plan, establish the rights and obligations with respect to Participants employed on and after January 1, 2020 and supersede all prior documents, instruments and communications issued by the Company with respect to benefits provided under the Welfare Plans on and after January 1, 2020. Subject to the terms of the collective bargaining agreement(s) covering the employment of the individuals eligible to participate in the Plan, the Plan or any component benefit program may be amended from time to time at the Company's discretion, and the Company reserves the right to terminate the Plan or any component benefit program at any time at the Company's discretion.

# ARTICLE I DEFINITIONS

### 1.1 Definitions

"Account" means the balance of a bookkeeping account established for each Participant as of the applicable date. "Account" or "Accounts" shall include, a Premium Conversion Account, a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Affiliate" means any of the following entities: (a) any corporation or other business entity which is (i) a member of a controlled group of corporations (within the meaning of Section 414(b) of the Code) of which the Company is also a member; (ii) a trade or business under common control with the Company, within the meaning of Section 414(c) of the Code; (iii) a member of an affiliated service group (within the meaning of Section 414(m) of the Code) of which the Company is also a member; or (iv) required to be aggregated with the Company pursuant to regulations issued under Section 414(o) of the Code; or (b) any other corporation or entity related to the Company.

**"COBRA"** means the coverage rights conferred by Section 4980B, *et seq.* of the Code, as amended from time to time, and Section 601, *et seq.* of ERISA, as amended from time to time (as such statutes were created by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, and amended thereafter).

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

"Company" means Avaya Inc. and any successor or assignee thereof which legally assumes the obligations of the Company under the Plan.

"Compensation" means the cash wages or salary paid to a Participant.

"Dependent Care Flexible Spending Account" means the Account established and maintained to record the Participant's election to make contributions to such an Account and have eligible dependent care expenses reimbursed by the Plan pursuant to Article VI.

"Effective Date" means January 1, 20120, the date on which this amended and restated Plan is effective (except as otherwise provided herein). The Plan was originally effective as of January 1, 2007.

"Eligible Employee" means an Employee who satisfies the eligibility provisions of Article III.

"Employee" means individuals in a bargaining unit represented by a union where the collective bargaining agreement provides for participation under the Plan that are designated on the

The Associated Marketine Description

payroll of an Employer as a regular, active, full-time or part-time employee. Individuals who are not paid from the U.S. payroll of an Employer, who are employed by an independent company (such as an employment agency), or whose services are rendered pursuant to a collective bargaining agreement or other agreement excluding participation in the Plan are not considered Employees for purposes of this Plan. As used in this Plan, a "full-time" employee is an individual who works, on average, 40 or more hours per week. Individuals who work, on average, more than 25 hours per week but less than 40 hours per week are eligible for the same benefits as full-time employees as provided, however, that such part-time employees may have different cost, level of coverage, or plan value as may be provided in the applicable Program Document.

**"Employer"** means the Company and any Affiliate that, with the consent of the Company, adopts the Plan by resolution of its Board of Directors or its delegate from time to time.

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

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

"GINA" means the Genetic Information Nondiscrimination Act of 2008, as amended from time to time, and the applicable regulations issued and effective thereunder.

"Health Care Flexible Spending Account" means the Account established and maintained to record the Participant's election to make contributions to such an Account and have eligible medical care expenses reimbursed by the Plan pursuant to Article VI.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations issued and effective thereunder.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act, as amended from time to time, and the applicable regulations issued and effective thereunder.

**"MHPA"** means the Mental Health Parity Act, as amended from time to time, and the applicable regulations issued and effective thereunder.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act, as amended from time to time, and the applicable regulations issued and effective thereunder.

"Michelle's Law" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence, as amended from time to time, and the applicable regulations issued and effective thereunder.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time, and the applicable regulations issued and effective thereunder.

"Participant" means an Eligible Employee or the covered eligible dependent of an Eligible Employee who satisfies the eligibility and participation provisions of Article III.

"Plan" means this the Avaya Inc. Health and Welfare Benefits Plan, as amended from time to time.

"Plan Administrator" means the Company or its delegate.

"Plan Sponsor" means the Company.

"Plan Year" means the twelve (12) consecutive month period beginning with January 1 and ending with December 31.

**"PPACA"** means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), and the applicable regulations issued and effective thereunder.

"Premium Conversion Account" means the Account established and maintained to record the Eligible Employee's election to have the Employer deduct the Eligible Employee's portion of the applicable plan or benefit program premiums or costs directly from the Eligible Employee's Compensation pursuant to Article VI.

"Program Document" means the written description of the terms of the Plan, including but not limited the group insurance contract issued by an insurance company, summary plan descriptions (including any and all summary of material modifications), schedule of benefits and benefits booklet, as such documents may be amended from time to time.

**"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and the applicable regulations issued and effective thereunder.

"Welfare Plan" means each welfare plan benefit offered under the Plan from time to time.

**"WHCRA"** means the Women's Health and Cancer Rights Act of 1998, as amended from time to time, and the applicable regulations issued and effective thereunder.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Participant with the Employer.

# ARTICLE II INTRODUCTION

### 2.1 Introduction

The Company, as Plan Sponsor, previously established the Plan to provide certain health benefits to its Eligible Employees, and their eligible spouse and eligible dependents from time to time.

The Plan is a group health plan (a type of welfare benefit plan that is subject to the provisions of ERISA). This document, its attachments, and the separate documents which describe the Plan from time to time (which are fully incorporated herein by this reference) constitute the written document as required by ERISA Section 402.

Certain benefit programs under the Plan are fully insured. Insured benefits of the Plan are provided under a group insurance contract entered into between the Company and the applicable insurance company from time to time. When the Plan refers to a group insurance contract, it also refers to any attachments to such contract, such as the application and the certificate of insurance booklet.

The Plan is to be administered and interpreted in a manner consistent with the applicable provisions of ERISA and the Code. Without limiting the generality of the preceding sentence, the Plan shall constitute a single plan for purposes of the applicable annual reporting requirements of ERISA and the Code.

The Plan shall apply only to eligible individuals who are Participants on or after the Effective Date.

## 2.2 Purpose of Document

This plan document is intended to address certain information that may not be addressed in the Program Document. This document, together with the Program Document and any other related documents issued by the Company from time to time and the applicable terms of the collective bargaining agreement(s), constitutes plan document required by ERISA. This plan document is not intended to, and does not, give any substantive rights to benefits that are not already provided by a Program Document.

# ARTICLE III ELIGIBILITY AND PARTICIPATION REQUIREMENTS

## 3.1 Eligibility and Participation

Employees are eligible to participate in the benefit program if they are an "Eligible Employee" and satisfy the eligibility provisions described in the Program Document. Unless otherwise provided in the Program Document, an Employee is an "Eligible Employee" if they are a regular full-time or part-time, represented Employee covered by a collective bargaining agreement that provides for the benefits provided under the Plan who works for Avaya Inc. or such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "Avaya Participating Company").

Unless otherwise provided in the Program Document, an Employee is not an "Eligible Employee" if:

- The employee is enrolled in an International Assignee plan and paid from the U.S. payroll of an Avaya Participating Company, or the employee is covered through Cigna Medical Benefits Abroad (MBA). Instead, this employee will receive necessary group medical, pharmacy and dental benefits through Cigna MBA. Cigna MBA may be contacted through International SOS (www.InternationalISOS.com) for specific information about group medical and pharmacy benefits.
- The Employee selects a non-Aetna medical plan through Avaya, such as Kaiser or HMSA.
   Instead, the Employee will receive medical benefits available through that plan. The carrier should be contacted for specific information about the coverage available.
- The employee is not paid from the U.S. payroll of an Avaya Participating Company, the
  employee is employed by an independent company (such as an employment agency), or the
  employee's services are rendered as part of an agreement excluding participation in
  benefits.
- The employee resides outside of the Aetna service area, for the Aetna Point-Of-Service Medical Plan.

No individual may receive benefits as a dependent of more than one Eligible Employee, or as both a dependent and as an Eligible Employee.

## 3.2 Qualified Medical Child Support Orders

The Plan shall extend benefits to an Eligible Employee's non-custodial child, as required by any qualified medical child support order (QMCSO) under ERISA Section 609 as provided in the Program Document. The Plan has procedures for determining whether an order qualifies as a

QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

### 3.3 Enrollment

Unless otherwise provided in the Program Document, the timeline for enrollment in Avaya's group medical benefit plans varies by employment status.

<b>Employment Status</b>	Timeline to Enroll	Eligibility Coverage Date
Newly-hired/rehired or newly-eligible active full-time or part-time Employees	Employees have 31 days from their eligibility coverage date to enroll in or waive coverage for themselves and/or their dependents	90 <sup>th</sup> day of net credited service*  * Note: Coverage may be obtained during the 90-day waiting period if the full cost of coverage is paid during the waiting period. The cost is waived the Employee has been continuously covered as a dependent of another Avaya employee or retiree.
Current active Eligible Employees	Within 31 days of a qualified status change (e.g. birth, adoption, marriage, death of dependent, divorce,	January 1 <sup>st</sup> of the following calendar year (after meeting the 90th day of net credited service)  Coverage eligibility date depends on a qualified status change. Coverage typically begins on the date of the
	involuntary loss of other group health coverage, etc.)	event or the first of the month following the event.

Unless otherwise provided in the Program Document, anticipated enrollment periods, such as new hire eligibility and annual enrollment, information will be e-mailed to Employees from *Avaya Health & Benefits* with instructions for enrollment. The e-mail will include information for the Employee about how to enroll themselves and their eligible dependents in the benefits enrollment portal at https://my.adp.com and the date by which elections must be made. If no e-mail is received and the enrollment deadline is nearing, the Avaya Health & Benefits Decision Center may be contacted for assistance (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

Unless otherwise provided in the Program Document, Employees are responsible for initiating qualified status changes within 31 days of the qualifying event (e.g. adding a newborn or dropping a divorced spouse) online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

If an enrollment deadline(s) is missed, the Employee may be negatively impacted for the remainder of the Plan Year. See "Failure to Enroll" and "Qualified Status Changes" for more detail.

Unless otherwise provided in the Program Document, elections are in effect as follows:

- The elections or waivers made as a newly-hired, rehired, or newly-eligible Employee are effective for the duration of the Plan Year of enrollment.
- The elections or waivers made during annual enrollment are in effect for the next full Plan Year.
- The elections or waivers made for a qualified status change are effective for the duration of the Plan Year in which an enrollment change is made.

## 3.4 Coverage for Dependents

Unless otherwise provided in the Program Document, eligible dependents can also participate in the Aetna Point of Service medical plan if coverage is elected for them. Dependents must be enrolled in the same benefit program in which the Employee is enrolled. Eligible dependents are defined by Avaya Inc. as:

- Lawful Spouse or Domestic Partner (either same-sex or opposite-sex; both parties must complete and file a notarized Domestic Partner Affidavit or government registration).
- **Children** To be eligible for medical, prescription drug and dental coverage, a dependent child must be under 26 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 26. An eligible dependent child includes:
  - A biological and/or legally adopted child, including any child in the formal legal process of adoption, regardless of residence;
  - A stepchild living with the Employee; and
  - A child living with the Employee for whom the Employee or the Employee's lawful spouse or domestic partner is the legal guardian (this does not include "wards of the state" or "foster children").

A child, for this purpose, does not include the spouse, domestic partner, or child(ren) of a child.

Unless otherwise provided in the Program Document, coverage for a disabled child may be extended past the age limits shown above if the disabled child:

- o Is not able to be self-supporting because of mental or physical disability, and
- O Depends mainly (more than 50% of income) on the Employee for support.

Validation that an Employee's child is disabled must be submitted to the Claims Administrator no later than 90 days after the date the child reaches the maximum age under the Plan. The application form must be completed and submitted for approval to the address listed on the form.

The Employee may be asked to send proof that their child is disabled after coverage is extended. The request for proof will not be requested more than once a year. The Employee must send the information within 31 days of the request; otherwise, coverage can be terminated for the dependent child.

No coverage is available for a child over age 26 who is incapacitated for a short time due to illness or accident.

## 3.5 Changing Benefit Elections

Unless otherwise provided in the Program Document, for most benefits Employees can make elections for themselves and their eligible dependents online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

The benefits enrollment portal is available year-round. Employees will use the portal as a new hire to initially enroll in benefits, during annual enrollment to update elections, and/or to make qualified status changes during the year. The benefits enrollment portal contains everything needed to make an informed decision, and a personalized enrollment webpage walks Employees through each of their election choices, benefit by benefit.

For example, when an Employee enrolls, they may:

- Change from the medical and pharmacy Default Option (defined below) and tier to another available plan and/or tier, when applicable,
- Enroll their eligible dependents in coverage (Note: after the election is approved proof of dependency (i.e. marriage license, Government Registration for Domestic Partners, birth

- certificate, etc.) must be submitted for each dependent newly added to coverage <u>before</u> their coverage will take effect),
- Enroll in or waive each Avaya Inc. benefit separately. For example, an Employee may waive medical coverage and still enroll in dental coverage for themselves and their dependents.

## 3.6 Default Option (Medical & Pharmacy Only)

Unless otherwise provided in the Program Document, most job classifications have a "Default Option" for medical and pharmacy benefits. When the benefit enrollment portal is viewed for the first time, a medical and pharmacy plan Default Option will already be selected. It is the Employee's responsibility to keep or amend the medical and pharmacy plan Default Option, and review all other benefits they are eligible for, within the 31-day election window. If the Employee does not change or waive the election, or if they fail to enroll altogether, the medical and pharmacy plan Default Option will be in force for the remainder of the Plan Year. All applicable payroll deductions will apply. The next opportunity to make changes to the Employee's benefits will be during the next annual enrollment period or within 31 days of a qualified status change.

Not all Employees have a Default Option. Eligibility for a Default Option depends on the Employee's job classification.

- Full-time and part-time represented Employees not living in Hawaii: the medical and pharmacy plan Default Option is employee-only coverage (no dependents are defaulted into coverage) in the Aetna Point of Service medical plan with pharmacy drug benefits provided by Express Scripts Inc.
- Represented Employees living in Hawaii: in accordance with Hawaii regulations, Eligible Employees residing in HI are limited to certain medical and pharmacy plans. Therefore, the medical and pharmacy plan Default Option is employee-only coverage (no dependents are defaulted in to coverage) in the HMSA PPP medical and pharmacy plan.

## 3.7 Failure to Enroll

Unless otherwise provided in the Program Document, if the enrollment deadline is missed, the Employee's coverage will remain *as is* for the remainder of the Plan Year. The Employee will have to wait until the next annual enrollment period to enroll in or change their election, unless the Employee has a mid-year qualified status change. For new hires and rehires, this means the Default Option will automatically be assigned (see "<u>Default Option (Medical & Pharmacy Only)</u>"). Existing Employees will retain their existing election with the exception of the Flexible Spending Accounts which must be elected during annual enrollment each year. All applicable payroll contributions will apply.

Similarly, if an Employee's eligible dependent(s) are not enrolled within 31 days of the hire/rehire/eligibility date or within 31 days of a qualified status change, or if proper proof of the dependents' eligibility for benefits is not submitted by the deadline on the dependent verification letter, the Employee's dependent(s) will not be covered for the remainder of the Plan Year. The Employee will have to wait until the next annual enrollment period to enroll their eligible dependents and provide proof of dependency, unless there is a mid-year qualified status change.

## 3.8 Employee Costs

The cost for each benefit can be found online at https://my.adp.com.

## 3.9 Payroll Deductions

Payroll deductions for benefits, if applicable, are clearly indicated on the Employee's pay statement (paystub).

- For new hires/rehires and for benefit changes made during the year (for qualified status changes), deductions/contributions generally begin within 1-2 pay periods (prospectively, as soon as administratively feasible) after the Employee's enrollment is received and processed, if applicable.
- For elections made during annual enrollment your deductions/contributions begin on the Employee's first paycheck in January, if applicable.

## 3.10 Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period. Article VI of this Plan and the Program Documents contain information about the special enrollment rights (if any).

## 3.11 Termination of Participation

A Participant's coverage (and the coverage of his or her eligible family members) shall terminate as provided in Article VI of this Plan and the applicable Program Document. Coverage shall also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, or denial of benefits. Article VI and the applicable Program Document provide additional information.

# 3.12 COBRA Continuation Coverage

If the health insurance coverage for a Participant or his or her covered eligible family members ceases because of certain "qualifying events" specified in COBRA (for example, divorce, death, or a child's ceasing to meet the definition of dependent), then the Participant or his or her covered eligible family members may have the right to purchase continuation coverage for a temporary period of time. More information about COBRA rights (if any) is included in the Program Documents and other COBRA information provided to Participants from time to time. Continuation of coverage shall also be made available as required by applicable state law.

# ARTICLE IV PLAN BENEFITS

### 4.1 Benefits Provided

The Plan provides health coverage to Eligible Employees and their eligible spouse and dependents. The benefits provided under the Plan are set forth in the applicable Program Document. A summary of the benefits provided under the Plan is set forth in the Program Documents.

# 4.2 Preexisting Conditions and Other Exclusions

Subject to applicable legal requirements and as applicable, Eligible Employees and their eligible spouse and dependents may be subject to preexisting conditions and other exclusions under the Plan from time to time. Also, Eligible Employees and their eligible spouse and dependents may be entitled to a reduction or an elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if they have creditable coverage from another plan. The Program Document contains information about the exclusions due to preexisting conditions and other exclusions, to the extent applicable.

## 4.3 Funding

Except as otherwise required by law, any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made out of the general assets of the Employer or the insurance contracts, as applicable.

The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

## 4.4 Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for promptly refunding the overpayment to the Plan to the fullest extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance company, Plan Administrator, or the Plan Sponsor may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made

due to the insurance company's, Plan Administrator's or Plan Sponsor's own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment; (b) as a reduction of the amount of future benefits otherwise payable under the Plan; or (c) any other method as may be required or permitted in the sole discretion of the Plan Administrator or insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

The Program Documents contain additional information about the Plan's right to subrogation or reimbursement of benefits.

# 4.5 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, insurance company and the Plan Sponsor with his or her current address. If required by the insurance company, each employee who is a Participant shall be responsible for providing the insurance company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Plan Administrator, insurance company and the Plan Sponsor shall have no obligation or duty to locate a Participant.

## 4.6 Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or insurance company with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan.

If a person is found to have falsified any document in support of coverage or a claim for benefits under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator or insurance company may, without the consent of any person, and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Participant related to the person submitting the falsified information. Such person shall be responsible, to the fullest extent permitted by applicable law, to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

# ARTICLE V PLAN ADMINISTRATION

### **5.1** Plan Administration

The Plan Administrator and the insurance company share responsibility for administering the Plan. The Plan Administrator is the named fiduciary. The Company may designate an individual, committee or third-party administrator to act on its behalf as Plan Administrator from time to time.

## **5.2** HIPAA Privacy Rules

- (a) Application. This Section 5.2 shall only apply to the extent that this Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act.
- (b) Privacy Policy. The Plan shall adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.
- (c) Business Associate Agreement. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.
- (d) Notice of Privacy Practices. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.
- (e) Disclosure to the Company.
  - (i) In General. This Subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the Employer to the extent that such PHI is necessary for the Employer to carry out its administrative functions related to the Plan.
  - (ii) Permitted Disclosure. The Plan may disclose the PHI to the Employer that is necessary for the Employer to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Employer may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Subsection.

- (iii) Limitations. The Employer agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:
  - A. Use and Further Disclosure. The Employer shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Plan, the Employer shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
  - B. Agents and Subcontractors. The Employer shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Employer with respect to such information.
  - C. Employment-Related Actions. Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Employer shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Employer.
  - D. Reporting of Improper Use or Disclosure. The Employer shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.
  - E. Adequate Protection. The Employer shall provide adequate protection of PHI and separation between the Plan and the Employer by: (i) ensuring that only those employees who work in the human resources department of the Employer on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the Employer on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and (iv) using the Employer's established disciplinary procedures to resolve

issues of noncompliance by the employees identified in clause (i) above.

- F. Return or Destruction of PHI. If feasible, the Employer shall return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- G. Participant Rights. The Employer shall provide Participants with the following rights: (i) the right to access their PHI in accordance with 45 C.F.R. Section 164.524; (ii) the right to amend their PHI upon request (or the Employer will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. Section 164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. Section 164.528.
- H. Cooperation with HHS. The Employer shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

(iv) Certification. By executing the Plan, the Employer hereby certifies that the Plan documents have been amended in accordance with 45 C.F.R. Section 164.504(f), and that the Employer shall protect the PHI as described in Subsection 3 herein.

- (v) Security Standards Requirement. To comply with the Security Standards regulations that were published on February 21, 2003, the Employer must:
  - A. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

- B. ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- D. report to the Plan any security incident of which it becomes aware.

## (vi) Amendment.

Notwithstanding any other provision of the Plan, this Section may be amended in any way and at any time by the Employer's privacy officer.

(vii) Effective Dates. Subsections (i) - (iv) and Subsection (vi) apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Subsection (v) applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

## **5.3** HIPAA Portability Rules

The Plan shall comply with the requirements of Code section 9801 et. seq. including the requirement to cover children until the attainment of age 26, if the Plan makes dependent coverage of children available. The Plan Administrator shall only provide a certificate of creditable coverage to the extent the underlying insurance constitutes a group health plan as defined in Treas. Reg. section 54.9801-2.

# ARTICLE VI CAFETERIA PLAN

### 6.1 Cafeteria Plan

The purpose of the cafeteria plan is to provide Participants the opportunity to receive certain Plan benefits on a pre-tax basis. As such, Participants have the option of exchanging all or part of their Compensation for Plan benefits they select. The cafeteria plan is intended to be a "cafeteria plan" within the meaning of Code section 125.

Except as provided in Article X, all other provisions of the Plan shall continue to apply with respect to benefits covered under this cafeteria plan.

## 6.2 Participation

An employee shall be eligible to enroll in the Premium Conversion Account if the employee is eligible to participate in the applicable Welfare Plan. Such Employee shall become eligible to become a Participant with respect to the Premium Conversion Account on the same date that he or she becomes eligible to participate in the applicable Welfare Plan.

### 6.3 Transfers

If a change in job classification or a transfer results in an individual no longer qualifying as a Eligible Employee, such Employee shall cease to be a Participant for purposes of the Premium Conversion Account (or shall not become eligible to become an Eligible Employee) as of the last day of the month that includes the effective date of such change of job classification or transfer (if he or she elects to end coverage). Notwithstanding the above, the individual shall cease to be a Participant for purposes of the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account as of the last day of the month that includes the effective date of such change in job classification or transfer.

Should the individual again qualify as an Eligible Employee, he or she shall become eligible to participate in all Accounts as of the first day of the month following the date of the event; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 6.11(b) below.

## 6.4 Termination and Rehires

(a) Participants. If a Participant has a Termination of Employment, such Employee shall cease to be a Participant for purposes of this Article VI as of his Termination of Employment. The Plan Administrator may continue participation for purposes of this Article VI until the end of the time period established by the Program Document or Plan Administrator procedures. An individual who has satisfied the applicable eligibility requirements of this Plan as of his Termination date, and

who is subsequently reemployed by the Employer as an Eligible Employee, shall resume or may become a Participant on the first day of the month coincident with or following his date of reemployment. Notwithstanding the foregoing, the Plan Administrator shall automatically reinstate benefit elections on the first day of the month coincident with or following the date of reemployment for Terminated Participants who are rehired within 91 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 91 days after Termination except as may otherwise be provided by the Program Document.

(b) Non-Eligible Employees. An Employee who has not satisfied the applicable eligibility requirement set forth in this Plan on his Termination date, and who is subsequently reemployed by the Employer as an Eligible Employee, shall be eligible to participate on the date the individual meets the eligibility requirements of this Plan.

## 6.5 Procedures for Enrollment

The Plan Administrator shall prescribe such forms (which may include online completion of enrollment) and may require such data from Eligible Employees as are reasonably required to effectuate any elections made pursuant to this Article VI. The Plan Administrator has sole and absolute authority and discretion to determine the deadline for the completion of enrollment.

### 6.6 Premium Conversion Accounts

- (a) In General. Each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Employer toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums or costs that may be reimbursed from the Premium Conversion Account shall not exceed the employee-paid portion of premiums or costs payable under the Program Documents. If an insurance contract is offered in conjunction with an Employer-sponsored benefit plan offered under the Plan, a Participant shall be eligible to make contributions to the Premium Conversion Account with respect to that Program Document only if he or she is also eligible to participate in the applicable Welfare Plan(s).
- (b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and will be debited for amounts applied to employee-paid portion of applicable premiums or costs. However, the Plan Administrator reserves the right to not direct the Employer to pay any premium or cost on an insurance contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

# 6.7 Health Care Flexible Spending Accounts

- (a) In General. Each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Employer toward the Health Care Flexible Spending Account described in Subsection (b). The amount of such salary reduction contributions to the Health Care Flexible Spending Account shall be set by the Employer, but shall in no event exceed the maximum annual limit permitted under Code section 125(i). The Account established under this Section 6.7 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.
- (b) Health Care Flexible Spending Account. Each Participant's Health Care Flexible Spending Account will be credited with amounts withheld from the Participant's Compensation and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Flexible Spending Account less any reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Flexible Spending Account provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.
- (c) Eligible Expenses. A Participant may be reimbursed from his or her Health Care Flexible Spending Account for expenses incurred for "medical care" as defined in Code section 213(d) (including expenses for a spouse and all dependents) that are: (i) incurred in the Plan Year, (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source.
  - (i) For purposes of Code section 105(b), dependents shall include all dependents within the meaning of Code section 152 as modified by Code section 105(b), and any child (as defined in Code section 152(0(1)) of the Participant until his or her 26th birthday.
  - (ii) For purposes of Code section 105(b), expenses for a child may be covered until the end of the month in which the child turns age 26.
  - (iii) Reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined

without regard to whether such drug is available without a prescription) or is insulin.

# 6.8 Dependent Care Flexible Spending Accounts

- (a) In General. Each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Employer toward the Dependent Care Flexible Spending Account described in Subsection (b). The Account established under this Section 6.8 is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.
- (b) Dependent Care Flexible Spending Account. Each Participant's Dependent Care Flexible Spending Account will be credited with amounts withheld from the Participant's Compensation and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Flexible Spending Account.
- (c) Eligible Expenses.
  - (i) In General. A Participant may be reimbursed from his or her Dependent Care Flexible Spending Account to the extent that such reimbursement: (i) is incurred in the Plan Year, (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.
  - (ii) Dependent Care Expenses. Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection which are

incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant's household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than 6 individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(iii) Limits. The maximum amount of expense that may be contributed/reimbursed in any taxable year for the Dependent Care Flexible Spending Account is the maximum amount permitted by federal tax law (for 2020, \$5,000 or \$2,500 if the Participant is married and filing a separate federal tax return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) shall apply in determining earned income.

(d) Participants that cease to participate in the Plan (due to Termination or any other reason) may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of participation occurs to the extent the claims do not exceed the balance of the Dependent Care Flexible Spending Account.

## 6.9 Forfeitures/Transfers

- (a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year shall be forfeited and shall remain the property of the Employer. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.13(b).
- (b) Transfers. Amounts may not be transferred between Accounts.

## 6.10 Elections

(a) New Employees. The Plan Administrator shall provide, where possible, an election form to the Employee before such employee meets the eligibility

requirements of this Plan. In order to participate in the Plan, the employee must return the completed election form to the Plan Administrator (or complete online enrollment, if available) on or before such date as specified by the Plan Administrator. However, any election shall not be effective until a pay period following the later of such Participant's effective date of participation or the date of the receipt of the election form by the Plan Administrator and shall be limited to the expenses incurred after the effective date of the election.

- (b) Continuing Participants and Employees. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an election form (or provide access to online enrollment, if available) to each Participant and to each other individual who is expected to become an Employee at the beginning of such Plan Year. In order to participate in the Plan in the applicable Plan Year, the Employee and Participant must return the completed election form to the Plan Administrator (or complete online enrollment, if available) on or before such date specified by the Plan Administrator procedures, which date shall be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.
- (c) Failure to Return Election Form. The failure of an Employee described in Subsection (a) to return a completed election form to the Plan Administrator (or complete online enrollment, if available) on or before the specified due date shall constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of an employee described in Subsection (b) to return a completed election form to the Plan Administrator (or complete online enrollment, if available) on or before the specified due date shall constitute an election not to participate in the Plan for purposes of this Article VI for the applicable Plan Year unless a default election is otherwise specified under Subsection (d).
- (d) Premium Conversion Account Special Election Rules. An Eligible Employee shall be deemed to elect to contribute the entire amount of any premiums or costs payable by the Eligible Employee for the benefits described in Section 6.6 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. An Eligible Employee's election for benefits described in Section 6.6 shall be automatically adjusted for any change in the premiums or costs pursuant to the terms of Treas. Reg. 1.125-4.
- (e) Form of Elections. All elections shall be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

- Leave of Absence/FMLA/USERRA. The Plan Administrator shall permit a (f) Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. The Plan Administrator shall also permit a Participant taking unpaid Non-FMLA leave to continue the benefits. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium or cost payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums or costs and resume premium or cost payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the USERRA and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law. Administrator shall have sole discretion to determine how to recoup unpaid premiums or costs that may be due while the Participant is on unpaid leave.
- (g) COBRA. A Participant shall be entitled to continuation coverage as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.
- (h) Procedures. A Participant shall make the elections described in this Section in such form and manner as may be prescribed by the Plan Administrator and at such time in advance as the Plan Administrator may require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

### 6.11 Revocation of Elections

(a) By Participant. Any election made under Section 6.10 shall be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions under FMLA or other applicable law and is permitted under Treas. Reg. 1.125-4, IRS Notice 2014-55 and under Subsection (b).

- (b) Elections may be modified, at any time permitted under Treas. Reg. section 1.125-4, upon the occurrence of any of the following events, provided the Participant files the required form with the Plan Administrator within 31 days (or such longer period as may be provided by the Plan Administrator and/or insurance contract) of the qualified life event:
  - (i) HIPAA Special Enrollment Rights. A Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).
  - (ii) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(E) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.
  - A. Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.
  - B. Number of Dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption or legal guardianship/foster care.
  - C. Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4, change in employment status resulting in gaining or losing eligibility under the Plan.
  - D. Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for

coverage on account of attainment of age, student status or any similar circumstance.

E. Residence. A change in the place of residence of the Participant, spouse, or dependent.

(iii) Significant Curtailment with Loss of Coverage. If the Participant's coverage option (or the Participant's spouse's or dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a loss of coverage during a plan year, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another option that provides similar coverage, or drop coverage if no other coverage option providing similar coverage is offered. This Subsection (iii) is not applicable to the health flexible spending account arrangement under the Plan. For purposes of this Subsection (iii), the following words and phrases have the respective meanings specified below:

A. A "loss of coverage" means a complete loss of coverage (including the elimination of a coverage option, an HMO ceasing to be available where the Participant or his or her spouse or dependent resides, or a Participant or his or her spouse or dependent losing all coverage under the coverage option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a loss of coverage:

- a. a substantial decrease in the medical care providers available under a health plan coverage option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or an HMO);
- b. a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her spouse or dependent is currently in a course of treatment; or
- c. any other similar fundamental loss of coverage.

- B. "Significantly curtailed" means there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.
- C. "Similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, a medical care spending account (MSA) is not similar coverage with respect to a health plan that is not an MSA; an HMO and PPO are considered to be similar coverage; and coverage by another employer, such as a spouse's or dependent's employer, is treated as similar coverage.
- (iv) Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:
- A. changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or
- B. cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.
- (v) Entitlement to Medicare, Medicaid or Children's Health Insurance Program ("CHIP"). A Participant may modify an election for benefits attributable to an Employer-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare, Medicaid or CHIP (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan shall be granted in the case of loss of coverage under Medicare, Medicaid or CHIP.

(vi) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 6.7, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

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

- (c) If a Participant revokes an election of coverage under a group health plan due to reduction in hours of service, the following conditions must be met:
  - (i) The Participant must have been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in the Participant's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change may revoke his or her election for medical benefit coverage, provided that the Participant (a) requests the election change within the Plan's election period and (b) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the medical benefit coverage is revoked; and

(ii) The Plan Administrator may rely on the reasonable representation of the Participant that the Participant has enrolled or intends to enroll in the other plan.

This Section shall be interpreted consistent with IRS Notice 2014-55 and any superseding guidance.

- (d) If a Participant revokes an election of coverage under a group health plan due to enrollment in a qualified health plan offered through a marketplace established under Code section 1311, the following conditions must be met:
  - (i) The Participant is eligible for a special enrollment period to enroll in a qualified health plan through the marketplace pursuant to guidance issued by the

Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual enrollment period; and

(ii) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked. The Plan Administrator may rely on the reasonable representation of the Participant that the Participant has enrolled or intends to enroll in the other qualified health plan.

This Section shall be interpreted consistent with IRS Notice 2014-55 and any superseding guidance.

- (e) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and nondiscriminatory manner.
- (f) Automatic Termination of Election. Any election made under this Section shall automatically terminate on the date specified in Sections 6.3 or 6.4.
- (g) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 6.11 and whether the Participant's requested election change is consistent with such event.

### 6.12 Nondiscrimination

- (a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.
- (b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 6.6, as applicable.

- (c) Health Care Flexible Spending Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 6.7.
- (d) Dependent Care Flexible Spending Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 6.8.

## 6.13 Limitations on Contributions

- (a) Cafeteria Plan. Key employees (within the meaning of Code section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all employees under the Plan.
- (b) Dependent Care Flexible Spending Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 25% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 6.8. The average benefits provided under Section 6.8 to Participants who are not highly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees of the Employer.

### 6.14 Procedures for Reimbursements

(a) All claims for benefits that are provided under Program Documents or under Sections 6.7 or 6.8 shall be made by the Participant in accordance with the procedures set forth in the applicable Program Document.

# ARTICLE VII DENIAL OR LOSS OF BENEFITS

#### 7.1 Denial or Loss of Benefits

A Participant's benefits (and the benefits of his or her eligible spouse and dependents) shall cease as provided in the Program Document (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

## 7.2 Other Circumstances

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The Program Documents provide additional information.				

# ARTICLE VIII AMENDMENT OR TERMINATION OF THE PLAN

### 8.1 Amendment

Subject to the terms of any collective bargaining agreement(s), the Company reserves the discretionary right to modify or amend the Plan, including any attachment hereto, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Board of Directors of the Company (or its designee), and duly executed on behalf of the Company. Subject to the terms of any collective bargaining agreement(s), the Plan Administrator shall have the right to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Plan Administrator that is inconsistent with any administrative, procedure or ministerial provision of the Plan shall be deemed an amendment. For this purpose, amending the Plan includes making changes to the related group health insurance contract.

## 8.2 Termination

Subject to the terms of any collective bargaining agreement(s), the Company reserves the right to terminate the Plan at any time as designated by a written instrument adopted by the Board of Directors or its designee and duly executed on behalf of the Company.

# ARTICLE IX CLAIMS PROCEDURES

### 9.1 Benefit Claim

The Plan Administrator or its delegate is responsible for evaluating all self-insured benefit claims under the Plan. The insurance company is responsible for evaluating all insured benefit claims under the Plan. The insurance company shall decide claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. For purposes of determining the amount of, and entitlement to, benefits under the group insurance contract, the insurance company has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the group insurance contract. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim. If the insurance company denies a claim, in whole or in part, the claimant will be provided written notice of the decision as required by ERISA and other applicable law.

The Program Documents, including the insurance booklet issued by the insurance company, provides information about how to file a claim and details regarding the Plan's claims procedures.

## 9.2 Appealing a Denied Claim

If a claim is denied, the claimant may appeal to the Plan Administrator or insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law.

## 9.3 Important Appeal Deadlines

If the claimant does not appeal on time, then he or she shall lose the right to file suit in a state or federal court, because he or she shall not have exhausted internal administrative appeal rights (which generally is a condition for bringing suit in court).

The Program Documents contain information about how to appeal a denied claim and for details regarding the Plan's claims procedures.

## 9.4 Limitations Period for Filing Suit

Unless specifically provided otherwise under a Program Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Claims and appeals procedures are provided in the Program Document.

# ARTICLE X GENERAL INFORMATION ABOUT THE PLAN

## 10.1 Limitation of Rights

The establishment, maintenance and provision of the Plan shall not be considered or construed as:

- (a) giving to any Employee any right to continue in the employment with any Employer or reemployment with any Employer;
- (b) limiting the right of any Employer to discipline or discharge any of its Employees;
- (c) creating any contract of employment or re-employment between any Employer and any Employee or Participant; or
- (d) conferring any legal or equitable right against the Plan Administrator, the Company or its Affiliates.

A statement of ERISA rights for each Participant is attached hereto.

# 10.2 Compliance With State and Federal Mandates

To the extent applicable, the Plan shall provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, Title I of GINA, and PPACA. Unless otherwise provided in the Program Document, the Employer does not intend to provide any substantive benefits other than those mandated under the applicable laws.

# 10.3 No Assignment

Unless specifically permitted by the Program Document, the right of any Participant to receive any benefits under the Plan shall not be alienable by assignment. In addition, the right of any Participant to receive any benefits shall not be subject to any claims by any creditor of or claimant against the Participant; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by the Participant to confer on any such creditor or claimant any right or interest with respect to such amounts, shall be null and void, except as provided in Section 609 of ERISA with respect to QMCSO or the Program Document. No contributions under this Plan shall cause the Employer or any Affiliate to be liable for, or subject to, any manner of debt or liability of any Participant.

## 10.4 Severability

Any provision of the Plan shall be severable, so that if any Plan provision is held invalid or unenforceable, such invalid or unenforceable provision shall be severed from the Plan and the Plan shall operate without regard to such severed provision.

#### 10.5 Insured Benefits

Benefits hereunder may be provided pursuant to a contract between the Company or Employer and an insurance company as in effect from time to time. If in such case the terms of this document conflict with the terms of the insurance contract, the terms of the insurance contract will control, unless contrary to applicable law.

## **10.6** No Guarantee of Tax Consequences

The Company makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludible from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. Each Participant is solely obligated to determine whether each payment under this Plan is excludible from the Participant's gross income for federal and state income tax purposes.

## 10.7 Headings

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

### 10.8 Gender and Number

Except as otherwise clearly indicated by the context, whenever used in the Plan a masculine pronoun shall include the feminine and neuter genders, words used in the singular shall include the plural, and words used in the plural shall include the singular, as circumstances make such meanings applicable.

# ATTACHMENT STATEMENT OF ERISA RIGHTS

## **Your Rights**

As a Participant in Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to the following.

You can examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including Program Documents and collective bargaining agreements, and a copy 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.

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

The Plan Administrator is required by law to furnish each Participant with a copy of the summary of his/her annual financial report.

### **Continue Group Health Plan Coverage**

You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan and the Program Document on the rules governing your COBRA continuation coverage rights.

## **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 people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's administrative claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court after you have exhausted the Plan's administrative claims procedures.

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 if, for example, it finds your claim is frivolous.

## **Limitations Period for Filing Suit**

Unless specifically provided otherwise under a Program Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Claims and appeals procedures are provided in the Program Document.

## **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan 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 Benefit 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.