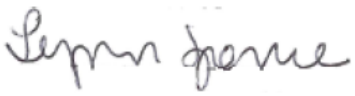
YOUR GOALS. OUR MISSION.

WHEREAS, T&M Associates, Inc. (the "Company") has established and presently maintains the T&M Associates Employee Welfare Plan (the "Plan), identified as plan number 502, for the benefit of its eligible employees and eligible spouses and dependents; and

WHEREAS, the Company desires to affirm and ratify the establishment of the Plan and the amendment and restatement of the Plan, and to document the Plan to satisfy the Employee Retirement Income Security Act ("ERISA") and Internal Revenue Code ("Code") documentation requirements for the Plan by creating a combined 'wraparound" plan/summary plan description document to serve as both the written plan document required under ERISA and the Code and the summary plan description for the Plan.

NOW, THEREFORE, BE IT RESOLVED, that the adoption of the Plan and the amendment and restatement of the Plan effective as of August 1, 2018 (with amendments through July 31, 2021), as reflected in the amended and restated T&M Associates Employee Welfare Plan Summary Plan Description and Plan Document, substantially in the form attached to these resolutions, shall be, and hereby are, affirmed, ratified, and approved; and be it

FURTHER RESOLVED, that the appropriate officers be and each of them hereby is, authorized and empowered, on behalf of the Company and in its name, to make all such arrangements, to do and perform all such acts and things, and to execute and deliver all such instruments and documents as they may deem necessary or appropriate in order to effectuate fully the purpose of each and all of the foregoing resolutions.



Lynn Spence
SVP, Chief People Officer

Employee Welfare Plan

Summary Plan Description and Plan Document

Amended and restated effective August 1, 2018 with amendments through July 31, 2021

This draft plan/SPD document, together with the incorporated documents, when adopted, will constitute a legal instrument with important tax and legal implications. Before you adopt it (in accordance with your standard business governance procedures), you should verify its accuracy and appropriateness for your benefit programs, and your legal advisor(s) should review and approve it.

Employee Welfare Plan

Summary Plan Description and Plan Document

Amended and restated effective August 1, 2018 with amendments through July 31, 2021

Contents

Introduction 1
Eligibility for Benefits 4
Enrollment 6
Cost of Coverage 9
Making Changes during the Year 11
Benefits 16
Medical 20
Prescription Drug Benefits 22
Health Savings Account (HSA) 23
Employee Assistance Plan 24
Dental 25
Vision 26
Life Insurance 27
Short-term Disability (STD) 28
Long-term Disability (LTD) 29
Personal Accident Insurance 30
Cancer Insurance 31
Specified Health Event Insurance 32
Flexible Spending Accounts (FSA) 33
Covered and Non-covered Services 34
Claims and Appeal Process 35
Coordination of Benefits 44
Third Party Recovery, Subrogation and Reimbursement Provisions 47
When Coverage Ends 52
Continuation Coverage 54
Converting Coverage After Termination 63
Coverage during Leave of Absence 64
Funding 66
ERISA 68
Plan Administration and Other General Information 70
Other Important Information 76
HIPAA Privacy and Security 79
Appendix A: Summary Plan Description Attachments 82
Appendix B: Participating in Benefits Attachments 83

This document incorporates by reference one or more specific booklets or plan summaries that describe in more detail certain of the benefit specific provisions governing the T & M Associates Employee Welfare Plan.

Introduction

This combined Summary Plan Description and Plan Document (the "Document") describes the health and welfare benefits and programs available to eligible employees of T & M Associates, Inc. (the "Company") under the T & M Associates Employee Welfare Plan (the "Plan") on or after their effective date(s) for participation. This Document, along with the other related documents provided by the carrier and third party administrators (such as certificates of insurance and descriptive booklets, which are incorporated into this Document), is designed to be your primary source of health and welfare benefits information. Refer to it for information about your benefits, and share it with your family members.

The Company maintains the Plan described herein for the exclusive benefit of its eligible employees and to provide various health and welfare group benefits through the following component benefit programs:

- Medical (including prescription drug)
- Health Savings Account (HSA)
- Dental
- Vision
- Employee Assistance Plan (EAP)
- Life Insurance Benefits
  - Basic Life
  - Voluntary Life
  - Dependent Life
- Accidental Death and Dismemberment (AD&D)
  - Basic AD&D
  - Voluntary AD&D
  - Dependent AD&D
- Short Term Disability (STD) (NJ Employees Only)
- Voluntary STD
- Long Term Disability (LTD)
- Voluntary LTD
- Health Flexible Spending Account (FSA)
- Dependent Care FSA
- Voluntary Personal Accident
- Voluntary Cancer
- Voluntary Specified Health Event
- Pre-Tax Salary Reduction Elections

Certain benefits offered under the Plan are currently provided under insurance contracts and administrative agreements entered into between the Company and various insurance carriers and third party administrators. These benefits are described in this document, and in the certificates of insurance and benefits booklets issued by the insurance companies and service providers, which are incorporated into this Document by reference.

This Document provides no guarantee that you are eligible to participate in every benefit or program described. Each benefit program may have its own eligibility requirements, so be sure to review individual eligibility requirements set forth in this Document and the booklets issued by the insurance companies and service providers carefully.

The Plan provides benefits in accordance with applicable federal laws including the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), Michelle's Law (when applicable), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addition Equity Act (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the Patient Protection and Affordable Care Act (PPACA) and its companion Health Care and Education Affordability Reconciliation Act.

The Plan, through this Document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Each benefit program has a benefit booklet. Refer to each program's booklet for much of the information about a program's benefits and rules.

This Document is a "wrap" document.

- It "wraps around" each benefit program booklet. Together, this Document and the benefit program booklet constitute the Summary Plan Description.
- For benefit programs that are insured, this document "wraps around" the insurance policy. Together, the wrap document and the insurance policy constitute the plan document for insurance programs.
- For benefit programs that are self-funded, this Document combined with the benefit program booklet and any other governing documents constitute the plan document for the self-funded benefit programs.

This Document is also intended to supplement the documents described above, which together comprise the official Plan document.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the Human Resources Department, 732-671-6400. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions about this Document or certain provisions of the Plan, please call the Human Resources Department at 732-671-6400.

Every effort has been made to ensure that the information in this Document is complete and accurate. However, if there is ever a conflict or a difference between what is written here and the related documents or insurance policies, the related documents or insurance policies will rule with respect to the specific benefits provided, unless otherwise provided by law. If there is ever a conflict or a difference between this Document and the related documents or insurance policies with respect to the legal compliance requirements under ERISA and any other federal law, this Document will rule, unless the provisions in the related documents are more generous for participants.

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, in its sole discretion and in accordance with the *Plan Amendment and Termination* section set forth below may amend or terminate any of the benefit programs or any provision of the Plan at any time. No termination or amendment shall operate to reduce the amount of any benefit payment under the Plan for charges incurred prior to the effective date of such termination or amendment.

This Document is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between the Company and any individual. Your employment is always on an at-will basis. The Company or you may terminate the employment relationship without notice at any time and for any reason.

Eligibility for Benefits

An eligible employee with respect to the programs described in this Document is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. You must satisfy the eligibility and participation requirements under a particular component benefit program, which may vary depending on the particular component program, in order to receive benefits under that program. Other individuals, such as an eligible employee's spouse, children, or other family members, may be eligible to participate in and receive benefits under one or more of the component benefit programs due to their relationship to an eligible employee. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility and coverage information found in Appendix B and the respective attachments to Appendix A.

An eligible employee begins participating in the Plan upon his or her election to participate in a component benefit program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the eligibility criteria and becoming covered under a component benefit program that does not require enrollment or an election. Eligibility for benefits will also be made available as required by any applicable state insurance law.

Documentation of dependents

If you elect coverage for yourself and your eligible dependents, you must certify in writing that your eligible dependents meet all Plan eligibility requirements. You must also provide social security numbers for your dependents as requested in order to cover dependents under the Plan. The Company maintains the right to request documentation from you at any time to ensure that your dependents meet the eligibility criteria. In the event you provide a false certification or false or misleading information, you will be required to reimburse the Company for all amounts paid by the Company on your behalf. Any fraudulent attempt to secure or maintain coverage for a non-eligible person may lead to disciplinary action, up to and including termination of employment.

Qualified medical child support orders (QMCSOs)

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

If a QMCSO requires the Plan to provide health coverage, dependent children may also include your children who do not live with you and for whom you do not provide financial support. In general, QMCSOs are orders under state law requiring a parent to provide health care support to a child – for example, in case of separation or divorce. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who do not reside with you. However, children who are no longer eligible, due to their age for example, cannot be added under a QMCSO.

You may obtain a copy of the Company's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

Notification

You are responsible for notifying the Plan Administration in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan Administration in such an event, see the *Continuation Coverage* section of this Document.

Additional information

Additional information regarding how and when you, your spouse and dependent children become eligible to participate in the benefit programs and any conditions and limitations to eligibility are provided in Appendix B and in the certificates of insurance and benefits booklets provided by the applicable insurance companies and/or service providers, provided as attachments to Appendix A.

Enrollment

In order to receive benefits under the Plan, some benefit programs require you to enroll, while for others, coverage is automatic:

Enrollment Is Required	Coverage is Automatic
- Medical Benefits - Dental Benefits - Vision Benefits - Health Flexible Spending Account (FSA) - Dependent Care FSA - Voluntary Long Term Disability - Voluntary Short Term Disability - Voluntary Life Benefit - Voluntary Accidental Death and Dismemberment (AD&D) Benefit - Dependent Life Benefit - Dependent AD&D - Voluntary Personal Accident - Voluntary Cancer - Voluntary Specified Health Event	- Employee Assistance Plan - Basic Life Insurance Benefits - Basic Accidental Death and Dismemberment (AD&D) Benefit - Long Term Disability - Short Term Disability (NJ Employees Only)

When coverage is automatic

You do not need to enroll yourself or elect to participate under the automatic programs listed above. The Company automatically enrolls you in these programs for which you are eligible at no cost to you.

When enrollment is required

The following rules apply if you are required to enroll yourself and/or your spouse and dependent children in a benefit program listed above.

You may enroll yourself and your spouse and/or eligible dependents: 1) when you first become eligible for participation in the Plan, 2) during the annual open enrollment period, 3) as a result of certain special enrollment rights discussed below, or 4) within 30 days following a qualified change in status.

Initial eligibility

You can enroll, make elections, and direct the Company to make salary reduction or deduction contributions only by filing the appropriate completed and signed election forms or agreements with the Plan Administrator (including telephonic, e-mail, website, Internet, or any other type of electronic forms or agreements provided by the Plan Administrator).

Generally, your coverage under the benefits program begins on the first day of the calendar month that falls on or next following the date you are eligible for coverage (after your Waiting Period) if you enroll on or before that date.

If you do not enroll when you are first eligible, you will be considered to have elected not to participate in the Plan for purposes of the elective benefits for that plan year (which means you would have to enroll during the next open enrollment period or when you experience a “special enrollment event” or “change in status”, as discussed below to enroll).

Annual open enrollment

If you are a current eligible employee, you may enroll for, change your coverage level, or waive coverage during annual open enrollment, which is typically held:

- in summer for all benefits other than the FSAs, and
- in November for the health and dependent care FSAs.

During annual open enrollment, you may change your elections for which enrollment is required without the normal restrictions that apply at other times of the year.

Annual open enrollment elections will be effective:

- the following August 1 for all benefits other than the FSAs, and
- the following January 1 for the FSA elections.

If you do not enroll during annual open enrollment, your coverage levels will continue from the previous year, except for elections to have amounts deducted from your pay with respect to the flexible spending account(s) and/or health savings account (HSA). You are required to enroll in the flexible spending account(s) and/or HSA during each annual open enrollment. If you do not elect each year to enroll in the flexible spending account(s), your participation in the flexible spending account(s) will terminate.

Special enrollment events under HIPAA

Under the Health Insurance Portability and Accountability Act ("HIPAA"), you have special enrollment rights under certain circumstances.

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) are eligible, but not enrolled, for coverage under the Plan while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change

within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

Questions should be directed to the Plan Administrator.

Qualified change in status

You may also enroll yourself, your spouse and/or your eligible dependents for coverage mid-year in certain circumstances. See the section titled “Making Changes during the Year” below, for more information.

Cost of Coverage

The Company may pay the entire cost of certain benefit programs offered under the Plan and for some benefits, employees may pay the entire cost. For certain other benefit programs offered under the Plan, the employee and the Company may share the cost of coverage. Your portion of the cost for programs under the Plan will vary according to the benefits and coverage levels (i.e., single, family, etc.) you elect. You will receive information about your portion of the cost (including information on any wellness incentives integrated with the medical plans) for the benefit programs offered under the Plan during open enrollment or for new hires before you enroll. You may also obtain this information by contacting the Plan Administrator.

You may elect to have your cost for medical, vision, dental, health savings account (HSA) and the health and dependent care FSAs deducted from your pay on a before-tax basis under the cafeteria plan option offered by the Company. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money. Contributions may, however, be subject to state or local income taxes in some states.

The chart below shows the different coverages available. It also shows which coverages the Company pays, which coverages you pay for on your own, which coverages you and the Company pay for together, and how you pay your share of the cost (pre- or after-tax).

Coverage	Company pays	You pay	You and Company pay	You pay pre- or after-tax
Medical (including prescription drug)			X	Pre-Tax
Health Savings Account (HSA)			X	Pre-Tax
Dental			X	Pre-Tax
Vision		X		Pre-Tax
Employee Life and AD&D				
• Basic Life/AD&D	X			N/A
• Optional Life/AD&D		X		After-Tax
Dependent Life/AD&D		X		After-Tax
Voluntary Personal Accident		X		Pre-Tax
Voluntary Cancer		X		Pre-Tax
Voluntary Specified Health Event		X		Pre-Tax
Employee Assistance Plan	X			N/A
Long Term Disability (LTD)				
• Basic LTD	X			N/A
• Optional LTD		X		After-Tax
Short Term Disability (STD)				

Coverage	Company pays	You pay	You and Company pay	You pay pre- or after-tax
• Basic STD (NJ Employees Only)	X			N/A
• Optional STD		X		After-Tax
FSAs		X		Pre-Tax

Social Security taxes

Please note that you will not be paying Social Security taxes on any before-tax contribution toward coverage under the benefit programs. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the benefit programs will normally be greater than any eventual reduction in Social Security benefits.

Making Changes during the Year

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at annual enrollment generally remain in effect for the following Plan Year.

Federal rules and regulations govern when you can change certain benefit coverage elections outside of annual open enrollment. These rules apply to before-tax coverage elections you make for your medical, vision, dental, and FSA coverages. Coverage election and changes for other benefits are also subject to these rules. Pre-tax benefits include certain voluntary benefits (including cancer protection insurance, personal accident insurance, and specified health event). These voluntary benefits are subject to ERISA.

In general, the benefit plans and coverage levels you choose at open enrollment remain in effect for the following (August 1 to July 31 for all benefits other than the FSAs, and January 1 to December 31 for FSA benefits). However, you may be able to change your medical, dental, vision and health care or dependent care FSA elections during the coverage year. If you experience a change in status, as further explained below. You must make any status-related changes to your coverage within 30 days of the change in status.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.).

Qualified changes in status

The following is a list of qualified changes in status that will allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status.** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment

- **Number of dependents.** Any event that changes your number of tax dependents, including birth, legal guardianship, death, adoption, and placement for adoption

- **Employment status.** Any event that changes your, your spouse's, or your other dependent's employment status and results in gaining or losing eligibility for coverage. Examples include:

    - beginning or terminating employment;
    - starting or returning from an unpaid leave of absence;
    - changing from part-time to full-time employment or vice versa; and
    - a change in work location.

- **Dependent status.** Any event that causes your tax dependent to become eligible or ineligible for coverage under the plan

- **Residence.** A change in residence that causes an employee, spouse, or dependent to gain or lose eligibility for a plan or a different benefit option available under the plan (e.g., moving outside your medical or dental program's network service area)

- **COBRA.** Eligibility of an employee, spouse, or dependent for COBRA

- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.

Except as otherwise provided in an underlying benefit summary or booklet, other eligible individuals may also be added when a spouse or dependent gains eligibility as a result of a change in status event. This is referred to as the "tag-along" rule. Whenever a change in status event results in eligibility for any other dependent, it would be "consistent" to add dependents that were previously eligible for coverage.

Consistency requirements

Except for election changes due to a HIPAA and or Medicare/CHIP special enrollment, the changes you make must be "due to and consistent with" your qualified change in status. To satisfy the federally required "consistency rule," your qualified change in status and corresponding change in coverage must meet **both** of the following requirements.

Effect on eligibility. Except for your dependent care FSA, the qualified change in status must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.

For your dependent care FSA, the qualified change in status must affect the amount of dependent care expenses eligible for reimbursement. For example, if your child reaches age 13, his or her dependent care expenses are no longer eligible for reimbursement.

Corresponding election change. The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the medical program, you may cancel medical coverage only for that dependent.

Additionally, you may increase, decrease or begin contributions to your health or dependent care FSA if you have or adopt a child or a child is placed with you for adoption. The Plan Administrator will determine whether a requested change is due to and consistent with a qualified change in status.

Coverage and cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as mid-year events affecting the cost of coverage or the type of coverage provided, as described below. Note: *These rules do not apply for purposes of a health FSA*. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Coverage events

If the Company adds or eliminates a coverage option in the middle of the coverage year, or if coverage sponsored by the Company is significantly limited or ends, you and your eligible dependents may revoke [your elections and elect coverage under another option that provides similar coverage. If no other similar coverage is available, you may revoke your existing election.

For example, if there is an overall reduction under a coverage option that reduces coverage to participants in general, participants enrolled in that coverage option may elect to enroll in another option providing similar coverage (if the other coverage option permits). Additionally, if the Company adds an HMO or other coverage option mid-year, participants can drop their existing coverage and enroll in the new coverage option (if the new coverage option permits). You or your eligible dependents may also enroll in the new coverage option even if not previously enrolled for coverage at all (if the new coverage option permits).

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by the Company), you may make a corresponding mid-year election change. This rule applies to the medical, vision, and dental programs, as well as the dependent care FSA.

If another employer's plan allows your spouse or other dependent to change his or her elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

Health FSA. You may not decrease or end health FSA contributions or enroll for a health FSA when your spouse becomes eligible for coverage under another plan. You may not end health FSA contributions if you become eligible for coverage under another plan.

Dependent care FSA. You may make a change in your dependent care FSA if you make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

If your dependent care provider reduces or increases the number of hours worked, you may make a corresponding change to your dependent care FSA election. For example, if your child starts school, causing a reduction in the number of hours he or she is in the care of a dependent care provider, you may decrease your dependent care FSA election.

You may increase, decrease, or end contributions to your dependent care FSA if you gain coverage under another plan. Similarly you may enroll for or increase contributions to a dependent care FSA if you lose coverage under another plan.

Cost events

You must contact the Plan Administrator within 30 days of a cost event. Otherwise, your next opportunity to make changes will be the next annual open enrollment period or when you have a qualified change in status or other applicable event, whichever occurs first.

Medical, dental and vision coverage costs. If your cost for medical, dental or vision coverage increases or decreases significantly during the year, you may make a corresponding election change. For example, you may elect another coverage option with similar coverage, or drop coverage if no similar coverage is available. Additionally, if there is a significant decrease in the cost of a coverage option during the year, you may enroll in that coverage option, even if you declined to enroll in that coverage option earlier.

Any change in the cost of your coverage option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Dependent care FSA. If you change your dependent care provider mid-year, you may change your dependent care FSA contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates mid-year, you may increase or decrease your contributions.

Other rules

Receipt of court orders and QMCSOs. You will be permitted to revoke an election for accident or health benefits during a period of coverage and make a new election if a judgment, decree, or order (collectively an "order") requires accident or health coverage for your child or for a foster child who is your dependent. The order must have resulted from a divorce, legal separation, annulment, or change in legal custody, and includes a qualified medical child support order (QMCSO). The plan may automatically change your benefit and contribution elections to provide coverage for your child if the order requires coverage under the plan.

You may also decrease your coverage for a child, if the order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefit elections under the Plan, to the extent permitted by the Code and the Plan.

Medicare or Medicaid entitlement. You may change an election for health coverage mid-year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your health coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding health coverage only for the person who loses eligibility for Medicare or Medicaid.

Reduction in hours. If you experience a change in employment status that results in you working less than 30 hours per week, you may prospectively drop your medical coverage under the Plan mid-year. In order to drop medical coverage under the Plan, you must enroll (and enroll any dependents whose medical coverage was dropped in connection with this event) in another medical plan that provides minimum essential coverage under Health Care Reform. The effective date of the new coverage can be no later than the first day of the second month following the month that includes the date the medical coverage under the Plan is revoked. You may not make changes to your health FSA under this event.

Enrollment in a public Marketplace health plan. If you are eligible to enroll in public Marketplace coverage (during a public Marketplace special or open enrollment period) you may prospectively drop medical coverage under the Plan, even if you remain eligible for coverage under the Plan. You must intend to enroll, or have enrolled, in public Marketplace coverage that is effective no later than the day after the last day your coverage under this Plan is dropped. You may not make changes to your health FSA under this event.

Family and Medical Leave Act. If you take an FMLA leave, you may continue your group health coverage for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. The Company may require that you continue all health benefits (including health FSA), provided that participants on non- FMLA paid leave are required to continue coverage. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute your share of the cost of group health coverage during the leave by pre-paying for your coverage on a pre-tax basis, paying for coverage during your leave on an after-tax basis, and/or catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the leave. If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

Special rules apply to your health care FSA. When you take an FMLA leave, the entire amount you elected under your health FSA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the health care FSA will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incurred after your coverage terminated.

If your coverage terminates during your leave, you may be reinstated in your health FSA elections, if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave, or you may elect to increase your contribution level to “make up” for the contributions you missed during your leave. If you simply resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave.

Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, you may not retroactively elect health FSA coverage for expenses incurred after your coverage terminated.

Non-health benefits during FMLA. If you take an FMLA leave, the entitlement to non-health benefits (such as dependent care FSA benefits) will be determined by the Company policy for providing such benefits when you are on non-FMLA leave. If the policy permits a participant to discontinue contributions while on leave, then you will, upon returning from leave, be required to repay the contributions not paid during the leave. Payment shall be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and you or as the
Plan Administrator otherwise deems appropriate.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage.

Deadline for making an election change

If you experience an event described above, your Plan Administrator must receive written notice of the election change within 30 days of the event. The Company reserves the right to request proof of a qualified change in status.

Change in election effective date

In general, your change in election will not be effective earlier than the first day of the month immediately following the date the appropriate election form is completed and returned to the Plan Administrator. However, any election change made due to the birth, adoption or placement for adoption of a child and made within 30 days of such event will be effective retroactive to the date of the birth, adoption or placement for adoption and you will be permitted to pay for this retroactive coverage with pre-tax salary deductions.

Compliance with nondiscrimination requirements

The Plan and the various benefit programs are required to meet certain nondiscrimination provisions as outlined by the Code. Your employer reserves the right to modify the amount of any benefit elections of the shareholders, officers, owners, and other highly compensated employees by the amount necessary to allow the Plan and its underlying benefit programs to satisfy these nondiscrimination requirements.

Benefits

The following pages contain a brief description of the various benefit options offered under the Plan. With respect to the specific benefit options offered under the Plan, you can find a more complete description of the level of benefits provided by consulting the benefit booklet issued by the applicable service provider or in the applicable certificates of insurance issued by the insurance companies. In addition, the booklets and/or certificates will inform you of the following:

- any special eligibility requirements;
- any termination of coverage rules (that is, circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefit that a Participant or beneficiary might otherwise reasonably expect the Plan to provide);
- any cost-sharing provisions, including premiums, deductibles, coinsurance and copayment amounts for which you or your beneficiary is responsible;
- any annual or lifetime caps or other limit of benefits;
- the extent to which preventive services are covered;
- whether, and under what circumstances, existing and new drugs are covered;
- whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
- any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- any conditions or limits applicable to obtaining emergency medical care;
- any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service; and
- other related provisions.

You may obtain copies of the booklets and/or certificates applicable to all benefits. If you need a copy, please contact the Plan Administrator.

Salary reduction contributions - Cafeteria Plan options

The Company offers its employees[1] a cafeteria plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) and the regulations thereunder (referred to in this Document as the Cafeteria Plan), to provide employees health and dependent care FSAs and the opportunity to make pre-tax contributions toward certain benefits. Under this Cafeteria Plan, you may elect to have your cost for medical, vision, dental, health savings account (HSA) and the health and dependent care FSAs deducted from your pay on a before-tax basis. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money. Contributions may, however, be subject to state or local income taxes. Pre-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money.

By electing one or more pre-tax premium payment benefits under the Cafeteria Plan option, you convert a portion of your pay for the Plan Year (or other coverage period) into contributions to the Plan to pay premium payment benefits you have elected to receive. The Plan's terms, as set forth in this Document and as amended from time to time, govern a covered employee's rights and obligations under the Plan. Salary reductions are applied by the Company to pay your share of the contributions for the premium payment benefits and, for the purposes of this Plan and the Internal Revenue Code (the Code), are considered to

[1] Members of an LLC, partners, or more than 2% shareholders in an S corporation are not permitted to participate in benefits offered under Code Section 125.

be employer contributions. Premiums payment benefits for COBRA coverage may be made on an after-tax basis, or alternatively, you may make an election to pay all or part of the premiums for COBRA coverage on a pre-tax basis for a dependent's coverage from current pay, so long as COBRA premiums are not prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

Covered employees may elect one or more of the following before-tax premium payment benefits:

Medical Premium Payment Benefit

If you are eligible for Company-sponsored medical benefits, you may elect any of the medical program options as the medical premium payment benefit. A description of the medical benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The medical benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Dental Premium Payment Benefit

If you are eligible for Company-sponsored dental benefits, you may elect any of the dental program options as the dental premium payment benefit. A description of the dental benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The dental benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Vision Premium Payment Benefit

If you are eligible for Company-sponsored vision benefits, you may elect the vision program as the vision premium payment benefit. A description of the vision benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The vision benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Health FSA Premium Payment

If you are eligible to participate in the health FSA, you may elect a contribution as the health FSA premium payment benefit, subject to the minimum and maximum amounts for the applicable plan year as set forth in the plan summary materials provided at enrollment. A description of the health FSA benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The health FSA benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Dependent Care FSA Premium Payment

If you are eligible to participate in the dependent care FSA, you may elect any whole dollar annual contribution amount of not more than $5,000 ($2,500 if married filing separately) as the dependent care FSA plan premium payment benefit.

A description of the dependent care FSA benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The dependent care FSA benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Health Savings Account (HSA) Premium Payment

If you are eligible to participate in the health savings account (HSA) and you participate in an employer-sponsored high deductible health plan that meets the requirements of Section 223 of the Code, you may elect any whole dollar annual contribution amount of not less than $100 (or such other amount as set forth in the HSA summary description) and not more than the maximum allowed under Section 223 of the Code as the health savings account premium payment benefit. A description of the HSA benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions are set forth in

the applicable attachment to Appendix A. The HSA benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Voluntary Premium Payment Benefit

If you are eligible for Company-sponsored voluntary benefits (including cancer protection insurance, personal accident insurance, and specified health event insurance), you may elect the voluntary program as the voluntary premium payment benefit. A description of the voluntary benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The voluntary benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Notification of premium payment benefit amounts

The Company will provide you with written notification of the amount of the premium payment benefits for each program offered under the Plan that requires an employee contribution before your initial and annual enrollment/election periods. The amount of the premium payment benefits will be the contributions required of an employee to participate in the group health or welfare benefit program(s) for which a premium payment benefit is available through the cafeteria plan option. The written notification is incorporated by reference and made a part of this Document.

Certain of the benefits are available for election on an after-tax contribution basis and may not be paid through the pre-tax premium payment benefit, such as voluntary and dependent life and AD&D, short-term disability and long-term disability benefits.

Application of other plans

If you are electing one or more premium payment benefits under the cafeteria plan option, you are subject to the provisions, conditions, limitations, and exclusions of the health and/or welfare benefit program(s) for the premium payment benefit which you elect.

Flexible spending account 0ptions

The health FSA component of this Plan is intended to qualify as a “self-insured medical reimbursement plan” under Code section 105, and the medical care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees’ gross income under Code section 105(b).

The dependent care FSA component of this Plan is intended to qualify as a “dependent care assistance program” under Code section 129, and the dependent care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees’ gross income under Code section 129(a).

The health FSA and the dependent care FSA components of this Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code sections 105 and 129. The health FSA component is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA. The terms and provisions of the health FSA and dependent care FSA benefits are more fully described in the applicable attachments to Appendix A.

Irrevocability of elections

Except as described in this Plan and the component documents, a participant's election under the Cafeteria Plan is irrevocable for the duration of the period of coverage to which it relates. In other words, unless an exception applies, the participant may not change any elections for the duration of the period of coverage regarding: (a) participation in this Plan; (b) salary reduction amounts; or (c) election of particular benefit package options.

Effect of mistakes

In the event of a mistake as to the eligibility or participation of an employee, the allocations made to the account of any participant, or the amount of benefits paid or to be paid to a participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld

or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such participant or other person the credits to the account or distributions to which he or she is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Company from compensation paid by the Company.

No guarantee of tax consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Cafeteria Plan will be excludable from the participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each participant to determine whether each payment under this Plan is excludable from the participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the participant has any reason to believe that such payment is not so excludable.

Indemnification of Company

If any participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such participant shall indemnify and reimburse the Company for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Medical

The Company's health benefits program provides eligible employees with the opportunity to elect medical (including prescription drug) benefits for themselves and their eligible employees and their covered spouses and dependents. Voluntary Personal Accident, Cancer and Specified Health Event insurance is also available for election by eligible employees.

The medical benefits available under the health benefits program are either self-insured by the Company and provided through contracts with the service providers and/or are insured and provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, coordination of benefits and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the medical plan. You may automatically access the online provider directory at your medical plan website or by calling your medical plan (see the *Plan Administration and Other General Information* section of this Document for websites, addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the health benefits are more fully described in the applicable attachments to Appendix A. For additional information regarding the medical benefits provided under the health benefits program, please contact the Plan Administrator.

The Company may also discount your contribution if you participate in certain wellness programs as described in your enrollment materials.

If you elect medical coverage under a high deductible health plan and are otherwise eligible, the Company allows you to make pre-tax contributions toward a health savings account (HSA). The Company may also make a contribution to your HSA as described in your enrollment materials.

Special rights for mothers and newborn children

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The health benefits program will provide certain benefits related to benefits received in connection with a mastectomy. The health benefits program shall include reconstructive surgery following a mastectomy.

If you or your dependent(s) (including your spouse) are receiving medical benefits under the health benefits program in connection with a mastectomy and you or your dependent(s) (including your spouse) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas.

Reconstructive benefits are subject to annual health benefits program deductibles and coinsurance provisions like other medical and surgical benefits covered under the health benefits program.

Prescription Drug Benefits

The Plan provides prescription drug benefits to eligible employees who elect medical coverage.

The prescription drug benefits are either self-insured by the Company and provided through contracts with the service providers and/or insured and provided through insurance contracts with certain insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about the amount payable, required deductibles, co-payments, maximums, limitations, coordination of benefits and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the plan. You may automatically access the online provider directory at your prescription drug vendor website or by calling your prescription drug vendor (see the *Plan Administration and Other General Information* section of this Document for websites and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the prescription drug benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the prescription benefits provided under the plan, please contact the Plan Administrator.

Health Savings Account (HSA)

The Plan provides eligible employees who elect HDHP medical coverage with an opportunity to elect (HSA) benefits. If you are eligible to participate in the HSA and you participate in an employer-sponsored high deductible health plan (HDHP) that meets the requirements of Section 223 of the Code, you may elect any whole dollar annual contribution subject to the minimum and maximum amounts allowed under Section 223 of the Code as the health savings account premium payment benefit. Employees participating in the HDHP/HSA may be eligible to receive an HSA employer contribution if offered for the plan year.

Note: If you elect health FSA benefits, you are generally prohibited from also electing HSA benefits or otherwise making contributions to an HSA.

The HSA benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) and Company contributions, if any, are detailed in the in the applicable attachments to Appendix A. The HSA funding feature is not intended to establish an ERISA plan.

The terms and provisions of the HSA benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the HSA benefits offered under the Plan, please contact the Plan Administrator.

Employee Assistance Plan

The Medical Plan provides confidential counseling and referral services at no cost to eligible employees and their covered spouses and dependents through an Employee Assistance Plan (EAP).

The EAP benefits are provided through contracts with the service providers and/or are provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. Any contact you have with the EAP is strictly confidential. Benefits offered under the EAP (including information about who is eligible to receive benefits, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

The terms and provisions of the EAP benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the EAP, please contact the Plan Administrator.

Dental

The benefits program provides eligible employees with the opportunity to elect dental benefits for themselves and their eligible employees and their covered spouses and dependents.

The dental benefits available are either self-insured by the Company and provided through contracts with the service providers and/or are insured and provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the dental plan. You may automatically access the online provider directory at your dental plan website or by calling your dental plan (see the *Plan Administration and Other General Information* section of this Document for websites, addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the dental benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the dental benefits provided under the plan, please contact the Plan Administrator.

Vision

The benefits program provides eligible employees with the opportunity to elect vision benefits for themselves and their eligible employees and their covered spouses and dependents.

The vision benefits are either self-insured by the Company and provided through contracts with the service providers, and/or are insured and provided through insurance contracts with the insurance providers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the vision plan. You may automatically access the online provider directory at your vision plan website or by calling your vision plan (see the *Plan Administration and Other General Information* section of this Document for websites, addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the vision benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the vision benefits provided under the plan, please contact the Plan Administrator.

Life Insurance

The life insurance benefits program provides eligible employees with life insurance benefit protection. Basic life and accidental death and dismemberment (AD&D) benefits are provided to employees, and voluntary life, AD&D, and dependent insurance benefits are also available for election by employees. The life insurance benefits are provided through insurance contracts with the insurance provider(s) described in the *Plan Administration and Other General Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable descriptions provided by the insurance provider(s). The descriptions are also available from the Plan Administrator.

Taxes on imputed income

In some cases, an additional amount of taxable pay, known as imputed income, may be added to your W-2 earnings. Imputed income is the amount the Internal Revenue Service (IRS) requires to be added to your taxable pay for the "value" of the Company-provided life insurance in excess of $50,000. The value of your insurance is not the face amount of your life insurance coverage over $50,000. Instead, the IRS assigns a dollar amount (premium) of taxable income for each $1,000 of life insurance over $50,000. The IRS determines this premium according to a formula using IRS Table I Rates. This excess cost is considered "imputed income" by the IRS and is subject to federal income taxes and Social Security and Medicare taxes.

The terms and provisions of the life insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the life insurance benefits offered under the life insurance benefits program, please contact the Plan Administrator.

Short-term Disability (STD)

The short-term disability (STD) program provides eligible employees with STD benefit protection. The STD program also provides eligible employees with an opportunity to elect voluntary STD benefit protection. The STD program provides an eligible employee with certain salary continuation benefits in the event that illness or injury prevents an eligible employee from working for a period of time.

The STD benefits are either self-insured by the Company and provided through contracts with the service providers listed in *the Plan Administration and Other General Information* section below, and/or are provided through insurance contracts with the insurance carrier (s) described in the *Plan Administration and Other General Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the applicable service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

The terms and provisions of the STD benefits are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the STD program, please contact the Plan Administrator.

Long-term Disability (LTD)

The long-term disability (LTD) program provides eligible employees with LTD benefit protection. The LTD program also provides eligible employees with an opportunity to elect voluntary LTD benefit protection. The LTD program provides an eligible employee with salary continuation in the event that illness or injury prevents an eligible employee from working for an extended period of time.

The LTD benefits are provided through insurance contracts with the insurance providers described in the *Plan Administration and Other General Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable certificate(s) of insurance provided by the insurance companies. The certificates are also available from the Plan Administrator.

The terms and provisions of the LTD benefits are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the LTD program, please contact the Plan Administrator.

Personal Accident Insurance

The Plan provides eligible employees with an opportunity to elect personal accident insurance benefits. The personal accident insurance benefits are provided under an insurance contract with an insurance company described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the personal accident insurance summary of benefits.

The terms and provisions of the personal accident insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the personal accident insurance benefits offered under the Plan, please contact the Plan Administrator.

Cancer Insurance

The Plan provides eligible employees with an opportunity to elect cancer insurance benefits. The cancer protection benefits are provided under an insurance contract with an insurance company described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the cancer insurance summary of benefits.

The terms and provisions of the cancer insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the cancer insurance benefits offered under the Plan, please contact the Plan Administrator.

Specified Health Event Insurance

The Plan provides eligible employees with an opportunity to elect specified health event insurance benefits. The specified health event insurance benefits are provided under an insurance contract with an insurance company described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the specified health event insurance summary of benefits.

The terms and provisions of the specified health event insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the specified health event insurance benefits offered under the Plan, please contact the Plan Administrator.

Flexible Spending Accounts (FSA)

Health flexible spending account

The Plan provides health flexible spending account (FSA) benefits to eligible employees. Health FSA benefits offer you the opportunity to save tax dollars on your eligible out-of-pocket health care costs. Here's how the account works: you make contributions to the FSA on a before-tax basis. You are then reimbursed from your account tax free. Because of the tax advantages that this account offers, it is subject to certain IRS restrictions.

Note: If you elect health FSA Benefits, you are generally prohibited from also electing HSA benefits or otherwise making contributions to an HSA.

The health FSA is currently administered under service contracts with the service providers described in the *Plan Administration and Other General Information* section of this Document.

These benefits (including information about who is eligible to receive benefits, the amount of contributions, maximums, limitations, and reimbursable expenses) are summarized in the descriptions attached at the *Summary Plan Description Attachments and Additional Benefits* section of this Document. The descriptions are also available from the Plan Administrator.

Note that the new health reform law established a new uniform standard for medical expenses under a health FSA. Effective January 1, 2011, distributions from health FSAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

For more information regarding the benefits offered under the health FSA program, please contact the Plan Administrator.

Dependent care flexible spending account

The Plan provides dependent care FSA benefits to eligible employees. Dependent care FSA benefits offer you the opportunity to save tax dollars on your eligible out-of-pocket dependent care costs. Here's how the account works: you make contributions to a dependent care FSA on a before-tax basis. You are then reimbursed from your account tax free. Because of the tax advantages that this account offers, it is subject to certain IRS restrictions.

The dependent care FSA is currently administered under service contracts with the service providers described in the *Plan Administration and Other General Information* section of this Document.

These benefits (including information about who is eligible to receive benefits, the amount of contributions, maximums, limitations, and eligible expenses) are summarized in the descriptions attached at the *Summary Plan Description Attachments and Additional Benefits* section of this Document. The descriptions are also available from the Plan Administrator.

For more information regarding the benefits offered under the dependent care FSA program, please contact the Plan Administrator.

Covered and Non-covered Services

See the certificates of insurance and benefits booklets provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services for your benefits.

Claims and Appeal Process

The descriptive booklet(s) provided by the third party administrator or insurance carrier include a complete explanation of your claims and appeals rights and responsibilities.

For information on how to file your initial claim, see the claim filing procedures described in the insurance contract or associated documents which describe each benefit program. In general, any participant or beneficiary under the Plan (or his/her duly authorized representative) (the "claimant") may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrator or Plan Administrator. (See the attached descriptive booklet(s) at Appendix A for more information.)

The Claims Administrator listed in the *Plan Administration and Other General Information* section below will process the payment of claims under the Plan and handle the related recordkeeping. The Company may act as the Claims Administrator for purposes of reviewing claims and claim denials under the Plan, or may designate other organizations or persons to act as the Claims Administrator for claims review and denials. With respect to fully insured benefits, the Claims Administrator is the insurance company. For more information on the Claims Administrator for purposes of claims review and denials under the self-insured benefits offered under the Plan, see the claim filing procedures described in the associated documents which describe the benefit program.

The Claims Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If the Claims Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

A benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed.

If you have any questions regarding how to file or appeal the initial claim, contact the appropriate Claims Administrator.

If your descriptive booklet does not include a complete explanation of your claims and appeals rights and responsibilities, the general rules under ERISA, which are described in this section, may apply. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply.

The plan intends to comply with the many changes that are required by new standards for internal claims and appeals and external reviews as required by the Affordable Care Act. See the applicable certificates and descriptive booklets for more information.

Filing a claim

For information on how to file your initial claim, see the claim filing procedures in the insurance contract or associated documents which describe the benefit program. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrator or Plan Administrator.

Claim-related definitions

Urgent care claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot

be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for medical benefits is urgent.

Pre-service claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-service claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent care claims

"Concurrent care claims" are claims in which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim", "pre-service claim", or "post-service claim", depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

In addition, in an urgent care situation in which the Plan previously approved a course of treatment and you wish to extend such treatments past the time period or number of treatments previously approved, you may request an extension to the course of treatments at least 24 hours prior to the time the treatments are scheduled to expire. The Plan must notify you of its determination of whether to grant the request within 24 hours of receipt of the claim.

Claim review procedures

The Claims Administrator listed in the *Plan Administration and Other General Information* section below will process the payment of claims under the Plan and handle the related recordkeeping. The Company may act as the Claims Administrator for purposes of reviewing claims and claim denials under the Plan, or may designate other organizations or persons to act as the Claims Administrator for claims review and denials. With respect to fully insured benefits, the Claims Administrator is the insurance company. For more information on the Claims Administrator for purposes of claims review and denials under the self-insured benefits offered under the Plan, see the claim filing procedures described in the associated documents which describe the benefit program. The Company or other designated Claims Administrator has full discretion and authority to determine all claims under the benefit programs. Any action or determination in the review procedure will be final, conclusive and binding on the Claims Administrator, Plan Administrator, the Company, you and your family members.

If you, your beneficiary or your authorized representative feel that any of the benefit programs have made an error concerning your benefits, you, your beneficiary or your authorized representative has the right to request reconsideration under the Plan in accordance with the applicable procedures. All requests for reconsideration shall be submitted in writing to the Claims Administrator.

Initial claim determination

Pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), for each of the Plan options, except for the cafeteria plan option, the health savings account (HSA) and the dependent care FSA, the Plan has a specific amount of time, by law, to evaluate and respond to a claim for benefits. The period of time the Plan has to evaluate and respond to a claim begins on the date the claim is first filed. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The following timeframes apply to the various types of claims that you may make under the Plan, depending on the benefit at issue:

Timeframes for initial claims decisions

Timeframes generally start when the Plan receives a claim. (But see the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally should be provided through in-hand delivery, mailed, or sent by electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health FSA claims are considered non-urgent "post-service" claims.

	Medical, Dental and Vision Plans — urgent care claims	Medical, Dental and Vision Plans — non-urgent "pre-service" claims	Medical, Dental, Vision and Health FSA Plans non-urgent "post-service" claims	Medical, Dental, and Vision Plans "concurrent care" decision to reduce benefits	Disability Plans	Life Insurance and Accidental Death & Dismemberment Plans
Timeframe for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, no later than 72 hours. If you request in advance to extend ongoing treatments, provide notice of determination as soon as possible taking into account medical exigencies, but no later than 24 hours.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan sufficiently in advance to give you an opportunity to appeal and obtain decision before benefit is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.
Extensions	The Plan has up to 48 hours (subject to decision being made as soon as possible) for missing claim information; this period measured from when information is received or extension period expires.	The Plan has up to 15 days if necessary due to matters beyond the plan's control and must provide extension notice before period ends.*	The Plan has up to 15 days if necessary due to matters beyond the Plan's control and must provide extension notice before period ends.*	N/A	The Plan has up to 30 days if necessary due to matters beyond the Plan's control. A second 30 day extension may also be permitted. The Plan must provide the extension notice before period(s) end.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours).	You have at least 45 days to provide any missing information.	Give claimant at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that claim is improperly filed or missing information must be provided by the Plan as soon as possible (no later than 24 hours).	Notice that claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days).	N/A	N/A	N/A	N/A

* 15 or 30-day extension period (whichever is applicable) is "tolled" until the claimant responds to the notice.

Adverse benefit determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" – a denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- an individual being ineligible to participate in the Plan;
- utilization review;
- a service being characterized as experimental or investigational or not medically necessary;
- a concurrent care decision; and/or
- certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at the time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

In the event of an adverse benefit determination, you will receive notice of the determination. The notice will include:

- the specific reasons for the adverse determination;
- the specific Plan provisions on which the determination is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the Plan's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- for adverse determinations involving urgent care, a description of the expedited review process for such claims (this notice may be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice).

For medical claims, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

For medical claims, the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the timeframes described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator set forth in the *Plan Administration and Other General Information* section of this Document.

Any appeal will be decided in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to later object to the decision and your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan).

Timeframes for appeals process

Timeframes for filing an appeal start when you receive written notice of the adverse benefit determination. The timeframes for providing a notice of the appeal decision (a "notice of benefit determination on review") start when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision should be provided through in-hand delivery, mailed, or sent by electronic delivery before the period expires, though urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days.

	Medical, Dental and Vision Plans — urgent care claims*	Medical, Dental and Vision Plans — non-urgent care pre-service claims*	Medical, Dental, Vision and Health FSA Plans — non-urgent care post-service claims*	Disability Plans	Life Insurance and Accidental Death & Dismemberment Plans
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Timeframe for Providing Notice	As soon as possible taking into account medical exigencies, but not later than 72 hours. Maximum 2 levels of mandatory review.	Within reasonable period of time appropriate to medical circumstances, but not later than 30 days. Maximum 2 levels of mandatory review. If 2 levels are used, notice must be provided within 15 days of each appeal.	Within reasonable period of time, but not later than 60 days. Maximum 2 levels of mandatory review. If 2 levels are used, notice must be provided within 30 days of each appeal.	Within reasonable period of time, but not later than 45 days. Maximum 2 levels of mandatory review.	Within reasonable period, but not later than 60 days.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request).	Additional 60 days if special circumstances require extension.
Quarterly Meeting Rule Alternative to Above Time Limits	None.	None.	None.	None.	Available.

***** An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claims, depending on the facts.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination which is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, but rather based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to a good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an urgent care claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the timeframes described above. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse determination on review;
- reference to the specific provisions of the Plan on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a description of your right to bring a civil action under ERISA following an adverse determination on review;
- if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- a description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For medical claims adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.
- For medical claims, the notice will also include:
- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal remedies

You will not be able to bring a legal or equitable action for benefits under the Plan or any benefit program unless and until you have:

- submitted a claim for benefits in accordance with the foregoing applicable description of the claims process,
- you have been notified by the Claims Administrator that the claim has been denied, and
- you have filed a written request for a review of the claim in accordance with the foregoing applicable description of claims appeal procedures and the denial of the claim has been affirmed.

However, you will be entitled to bring a legal action on any claim if the Claims Administrator has failed to take any action on the claim within the time permitted for reviewing the claim as discussed in the chart above.

Unclaimed benefits

The Plan Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to affect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 12 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Plan Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable. If the unclaimed benefits provisions in this Document conflict with the unclaimed benefits provisions in an insurance contract governing benefits at issue, the unclaimed benefits provisions in the insurance contract will govern.

Coordination of Benefits

Coordination of benefits provisions apply to the health plans only and, to the extent that these provisions are not described in the applicable certificates or descriptive booklets, are described in this section. To the extent that the descriptive booklet(s) provided by the third party administrator or insurance carrier includes coordination of benefit provisions, the provisions of the descriptive booklet(s) will govern.

All payments under the plans described in this Document will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under this plan will be determined. One of the plans involved will pay benefits first — the Primary Plan — and the other plan(s) will pay benefits next — the Secondary Plan(s).

Allowable Expense: Includes any necessary, reasonable, and customary expense that would be covered in full or in part under the Plan. When a plan provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.

Plan: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured) or provides benefits on a prepaid or managed care basis (for example, PPO or HMO) or an indemnity basis, medical care components of group long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or other governmental benefits, as permitted by law. Also included are plans that provide coverage for students that are sponsored by, or provided through, a school or other educational institution, except for accident-type coverage for grammar and high school students.

Primary Plan: A benefit plan that has primary liability for a claim.

Secondary Plan: A benefit plan that adjusts its benefits by the amount payable under the Primary Plan. This Plan will be the Primary Plan on claims:

- for you, if you are not covered as an employee by another plan;
- for your spouse, if your spouse is not covered as an employee by another plan; and
- for your dependent children, the birthdays of the parents are used to determine which coverage is primary. This is the case if the parents are married to each other or not separated (whether or not they were ever married), or if a court decree awarding joint custody does not stipulate that one parent is responsible for the child's health care. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage (For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your children). If both parents have the same birthday, then the coverage that has been in effect the longest is primary.

When a child is claimed as a dependent by parents who are separated or divorced, the Primary Plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. If there is no court-ordered financial responsibility for the dependent child's health care expenses, the Plan will be Secondary. When a child's parents are separated or divorced and there is no court decree, then the Primary Plan will be determined in the following order:

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child; and
- the plan of the parent not having custody of the child.

The “birthday rule” described above applies if a court decree awarding joint custody does not stipulate that one parent is responsible for the child’s health care.

If the Plan is the Primary Plan, it will pay benefits first. Benefits will be calculated according to the terms of the Plan and will not be reduced due to benefits payable under other plans.

If the Plan is the Secondary Plan, benefits under the Plan may be reduced. The Claims Administrator will determine the amount the Plan normally would pay. Then the amount payable under the Primary Plan for the same expenses will be subtracted from the amount the Plan would have normally paid. The Plan will pay the difference. If the Plan is Secondary, you will never be paid more for the same expenses under both the Plan and the Primary Plan than the Plan would have paid alone.

When the Plan is the Secondary Plan and the patient is covered under an HMO, benefits under the Plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided, are rendered by the HMO.

In the event that a legal conflict exists between two plans as to which is the Primary Plan and which is the Secondary Plan, the plan that has covered the patient for the longer time will be considered the Primary Plan. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan’s coverage is automatically considered the Primary Plan.

Even if the Plan is your Primary Plan or Secondary Plan, in states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. In no fault states, all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The Plan will pay covered expenses not payable under the no-fault automobile insurance according to the coordination of benefit rules discussed above. Then, you can submit claims under another plan, such as your spouse’s employer’s plan, for any expenses not paid by the Plan. Depending on the coordination of benefit provisions of the other plan, you may or may not receive additional benefits.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and are covered under the Plan, the Plan continues to be the Primary Plan as long as you are an active employee. The Plan is Primary Plan for the following situations:

- eligible active employees age 65 and over and who are entitled to Medicare benefits;
- dependent spouses age 65 and over who participate in the Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- social Security disabled participants who are covered by the Plan on the basis of your active employment status with Company and who are entitled to Medicare benefits; and
- for the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

If you or a covered family member becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

Facility of payment

When benefit payments that would have been made under a Company plan have been made under another plan, the Plan has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the Plan and, to the extent of such payment, the Plan’s obligation to pay benefits will be satisfied. The Company will not have to pay that amount again. The term “payment made” also includes providing benefits in the form of services; in which case “payment made” means a reasonable cash value of the benefits provided in the form of services.

Right of recovery

The Plan has the right to recover any payment made in excess of the maximum amount payable under this provision. The Plan may recover from one or more of the following entities in an effort to make the plan whole:

- any persons it paid or for whom payment was made;
- any insurer, and any other organization; or
- any entity that was thereby enriched.

The "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Release of information

Certain facts are needed to apply the rules of this provision. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get the needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claims Administrator will determine the information necessary to operate this provision.

Third Party Recovery, Subrogation and Reimbursement Provisions

Payment condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a trustee over Plan assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery

through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to

administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

When Coverage Ends

Except as otherwise, provided under a plan specific summary or evidence of coverage booklet, your coverage under the Plan automatically will terminate on the earliest of the following dates:

- the date the Plan terminates;
- the date a particular benefit program terminates (for that benefit program only);
- the last day for which the necessary contributions are made;
- the last day of the month in which your employment terminates, you retire, you die or you otherwise cease to be eligible for coverage; or
- with respect to the participant, the date benefits paid on behalf of a participant equal the lifetime maximum benefit under a benefit program. (Applies to dental benefits only)

Except as otherwise provided under a plan specific summary or evidence of coverage booklet, your eligible dependent's coverage automatically will terminate on the earliest of the following dates:

- the date the Plan terminates;
- the date a particular benefit program terminates (for that benefit program only);
- the date on which your coverage terminates;
- the date you elect to terminate your eligible dependent's coverage;
- the last day for which the necessary contributions are made;
- the last day of the month in which the eligible dependent(s) ceases to be eligible for coverage;
- the date the eligible dependent(s) is covered as an employee under the Plan;
- the date the eligible dependent(s) is covered as the dependent of another employee under the Plan;
- the date the eligible dependent(s) enters the armed forces of any country or international organization; or
- the date the dependent is no longer eligible for coverage under a qualified medical child support order (QMCSO).

When an eligible employee's participation in the Plan terminates, benefits under the Plan for the eligible employee and covered persons covered through that eligible employee will cease. When an eligible employee's participation in a component benefit program terminates, benefits under that component benefit program for the eligible employee and covered persons covered through that eligible employee will cease. Termination of participation in a component benefit program occurs in accordance with the terms and conditions established for that program.

Employment termination

If you terminate employment, you will no longer be eligible to participate in the Plan. Typically, your pre-tax contributions will continue through your last regular payroll period. If you terminate employment and are rehired within 30 days, you will re-enter the Plan with the same election you had before you left. If you are rehired after 30 days, you may make a new benefit election for the remainder of the coverage year. Individuals rehired after 30 days will have to re-satisfy the applicable benefit waiting period. Please contact your Plan Administrator for more information on the options available to you.

If you are terminated and rehired, you will be treated as a new employee upon rehire only if you were not credited with an hour of service, as defined under Health Care Reform, with the Company (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 13 weeks. Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Termination of participation in the Plan will not affect any rights you may have to continue participation in certain group health plans. Your Plan Administrator will give you information on how to continue coverage under COBRA, if this is appropriate.

Continuation Coverage

There are several types of continuation coverage that may apply to particular component benefit programs, as highlighted below. For more information, see the attachments for the particular component benefit programs.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. Note also that state law may provide continuation and/or conversion coverage.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Company provide you and/or your spouse and covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue medical, dental, and vision coverage for a temporary period at group plan premium rates in certain instances where your coverage under the plans would otherwise end. These descriptive booklet(s) may also describe any state continuation of coverage laws that may provide additional protection to participants under insured arrangements and if so, those rules will apply.

As a qualified beneficiary, you can elect to continue the health coverage in effect on the date your coverage would otherwise end. You may also, under certain circumstances, be eligible to continue your participation in the health FSA. In general, health FSA continuation under COBRA is available only for the remainder of the year in which you terminate employment. You may not continue your dependent care FSA under COBRA. COBRA does not apply to the other non-health benefits offered under the Plan (for example, life insurance, AD&D, LTD, STD).

Qualified beneficiaries include you, your spouse, and dependent children who were covered under the Plan immediately before coverage ends. A qualified beneficiary also includes a child born to or placed for adoption with you the employee while enrolled in COBRA continuation coverage, provided you provide timely and proper notification of the birth or adoption.

Note that you may have options other than COBRA available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about the Marketplace, visit www.HealthCare.gov. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Company reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the health plans.

You will have 60 days from the date of the qualifying event to elect COBRA continuation coverage, or, if later, 60 days from the date the Plan Administrator or its agent sends a COBRA election notice to you. If you do not choose COBRA coverage within that time, you will not be eligible for COBRA coverage. See the *Electing COBRA* section below for more information.

You will have to pay the entire premium plus a 2% administrative fee (subject to any applicable government subsidy) for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. Your first premium payment is due within 45 days of the date of your election. See the *Cost of Coverage* section below for more information.

Contact information

If you have any questions about your COBRA rights, please read your Initial COBRA Notice, a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy. COBRA continuation is administered by the COBRA Administrator:

Benefit Express
1700 E. Golf Road, Suite 1000
Schaumburg, IL 60173

Who is covered

Employees

If you are an employee covered by a Company-sponsored group health plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period.

Spouse

If you are the spouse of an employee and are covered by a Company-sponsored plan on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Company-sponsored group health plan for any of the following four reasons:

- the death of your spouse;
- the termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment;
- divorce from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
- your spouse becomes entitled to (that is, covered by) Medicare.

Dependent Children

If you are a covered dependent child of an employee covered by a Company-sponsored plan on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following five reasons:

- the death of the employee;
- the termination of the employee's employment (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- the employee's divorce;
- the employee becomes entitled to (that is, covered by) Medicare; or
- the dependent ceases to be a "dependent child" under the Company-sponsored plan.

QMCSO: A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Company during the covered employee's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Your duties

Under the law, the employee or a family member has the responsibility to provide notice of a divorce, or a child losing dependent status under the Company-sponsored group health plan. The notice must include the following information:

- the name of the employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- the qualifying event giving rise to COBRA coverage;
- the date of the qualifying event; and
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if it is requested. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license(s), or marriage license.

You must mail or hand-deliver this notice to COBRA Administrator at the address listed in the *Contact Information* section above. This notice must be provided within 60 days from the date of the divorce, legal separation or child losing dependent status (or if later the date coverage would normally be lost because of the event). If the employee or a family member fails to provide this notice to COBRA Administrator during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage. See the *Electing COBRA* section below for more information.

If the employee or a family member fails to provide notice of the qualifying event to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage. If you or your family member fails to notify the COBRA Administrator of the qualifying event and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Company's duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage. The employee's:

- death,
- termination (for reasons other than gross misconduct),
- reduction in hours of employment, or
- medicare entitlement.

The Company will notify the Plan Administrator of a qualifying event within 30 days of the date of the qualifying event or, if later, date of the loss of coverage. If notice of the qualifying event is sent to the Plan Administrator within 30 days of the date of the loss of coverage, the duration of COBRA will be counted from the date that coverage ceases (not the date of the qualifying event). See Duration of COBRA section below for more information regarding the period of COBRA coverage.

Electing COBRA

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides you with notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage. To elect COBRA coverage you must complete the election form that is part of the Plan's COBRA election notice. You must mail or hand deliver this completed notice to the COBRA Administrator. Your

election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you choose continuation coverage, the Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the health plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. “Similarly situated” refers to a current employee or dependent who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the end of the month in which the qualifying event occurs. If you return your election form waiving your rights to COBRA and change your mind within the 60-day period, you may revoke your waiver and still elect COBRA coverage as long as it is within the 60-day window. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Newly eligible child: If you, a former employee of the Company elects COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary with his own rights to COBRA. If your dependent who is a qualified beneficiary elects COBRA coverage and then has a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is eligible for COBRA coverage as a dependent of the qualified beneficiary, but will NOT become a qualified beneficiary with his own rights to COBRA. In accordance with the terms of the Plan’s eligibility and other requirements for group health coverage and the requirements of federal law, these children can be added to COBRA coverage by providing the COBRA Administrator with notice of the new child’s birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and a copy of the birth certificate or adoption decree.

If you fail to notify COBRA Administrator within the 30 days, you will not be offered the option to elect COBRA coverage for the newly acquired child. Other newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee’s continuation coverage, if enrolled in a timely fashion, subject to the Plan’s rules for adding a new dependent.

Separate elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects. A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. And at subsequent open enrollments, a spouse or dependent child may elect a different coverage from the coverage the employee elects.

The Trade Adjustment Assistance Reauthorization Act of 2015 (the Trade Act): The 2015 Trade Act modified the expired Health Coverage Tax Credit (HCTC) and extended it for workers receiving Trade Adjustment Assistance, including workers with certain COBRA coverage and spousal group health plan coverage. The HCTC is a federally funded tax credit that allows individuals to pay only a portion of their qualified health insurance. The HCTC helps make health coverage more affordable for eligible individuals and their families by paying a significant portion of qualified health insurance premiums. Certain displaced workers are certified by the Department of Labor as eligible to receive Trade Readjustment Allowances under the Trade Adjustment Assistance program. Others may be eligible because they receive benefits from the Pension Benefit Guaranty Corporation and are 55 years old or older. Previously, those eligible for HCTC could claim the credit against the premiums they paid for certain health insurance coverage

(including COBRA) through 2013. The 2015 Trade Act is similar to the version of the credit that expired in 2013 but includes modifications that affect how the credit is administered. The IRS will provide ongoing guidance on the credit, including guidance for taxpayers who also qualify for premium assistance under the Affordable Care Act. More information about the Trade Act is available at https://www.doleta.gov/Tradeact/docs/program_brochure2014.pdf

Medicare and other coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify the Company if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. The 18-month COBRA coverage period begins on the later of the date of the qualifying event or the date coverage is lost. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

Additional qualifying events, which are an employee's death, divorce, legal separation, or Medicare entitlement or a child losing dependent status may occur while COBRA continuation coverage is in effect due to an employee's termination of employment or reduction in hours ("Second Qualifying Events"). Second Qualifying Events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage or the date coverage would have been lost due to the initial qualifying event.

Medicare: When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits within 18 months BEFORE termination or reduction of hours, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement.

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* section below for more information.

Your duties upon a second qualifying event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- the name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. You must mail or hand-deliver this notice to the COBRA Administrator at the address listed under the *Contact Information* section above. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates or driver's license.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Special rules for disability: If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. A qualified beneficiary must be determined, under the Social Security Act, to have been disabled and the disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally, 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and addresses of the disabled qualified beneficiary;
- the date that the qualified beneficiary become disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed under the *Contact Information* section above.

If, during the extended continued coverage period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this redetermination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner and include the same information required for, a notice of disability as described above.

Early termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- the Company no longer provides group health coverage to any of its employees;
- the premium for continuation coverage is not paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- the qualified beneficiary first becomes entitled to (covered by) Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- coverage has been extended for up to 29 months due to disability, and there has been a final determination under the Social Security Act that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security Administration determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the Company reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Company, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled.

COBRA and FMLA

If you take a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will have the right to elect COBRA if: (1) you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and (2) you lose group health coverage under the Plan because you do not return to work at the end of the FMLA leave.

COBRA coverage will begin on the earliest of the following to occur: (1) when you definitively informs the Company that you are not returning at the end of the leave; or (2) the end of the leave, assuming you do not return to work.

The Company will notify the Plan Administrator of your qualifying event within 30 days of the last day of FMLA leave, or if later, the date coverage terminates. Your maximum coverage period starts the later of the last day of FMLA leave or the date coverage terminates.

Health care flexible spending account COBRA coverage

You may also, under certain circumstances, be eligible to continue your participation in the health FSA. (You may not continue your dependent care FSA under COBRA). COBRA coverage under the health FSA

will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health FSA COBRA coverage that will be charged for the remainder of the plan year. In general, health FSA continuation under COBRA is available only for the remainder of the year in which you terminate employment. COBRA coverage for the health FSA, if elected, will consist of the health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply. All qualified beneficiaries who were covered under the health FSA will be covered together for health FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health FSA annual coverage limit and a separate COBRA premium.

Cost of coverage

You do not have to show that you are insurable to choose COBRA coverage. You will be required to pay the full cost of COBRA coverage. The amount you may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage). If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee and any eligible dependents, if applicable. This cost increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elected the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified by the COBRA Administrator of any cost changes.

COBRA coverage is not effective until you elect it and make the required payment. You have an initial grace period (45 days from the date of your initial election) to make your first premium payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payments. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you pay part but not all the premium, and the amount you paid is not significantly less than the full amount due, you will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due.

All COBRA premiums must be paid by check or money order, but you will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the Plan Administrator at the address listed below. If mailed, your payment is considered to have been made on the date that it is postmarked.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

Contacting the Company

If you have any questions about COBRA coverage or the application of the law, please contact the Plan Administrator. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep your plan informed of address changes

In order to protect your and your family's rights, you should keep the Company informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Company. Notices should be sent to the address listed above.

Converting Coverage After Termination

Contact your insured plan for information on converting to an individual policy. Many PPOs, HMOs, and other insured plans will permit you to continue membership or equivalent coverage on an individual policy. Conversion rights may also be available to your spouse and/or dependents when their coverage may not otherwise qualify for health insurance under normal circumstances. Due to this fact, however, the cost of the coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the Company health benefits program. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money.

For more information about conversion rights, contact the Plan Administrator.

Individual coverage after termination

You may be able to obtain coverage under an individual insurance policy issued by an insurance company..

The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies you should contact your State Insurance Commissioner's Office.

For information on individual plan options that might be available through the Health Insurance Marketplace, visit www.HealthCare.gov.

Coverage during Leave of Absence

If you go on an approved leave of absence, then entitlement to benefits will be determined by the Company policy for providing benefits during leave of absence. If you go on an unpaid leave of absence that does not affect eligibility for before-tax elections under the Plan, then you will continue to participate in these benefits and your contributions due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator.

When an employee is on a leave of absence (including FMLA, Workers Compensation, Personal Leave of Absence or Furlough) T&M Associates will continue his/her coverage under the group health (medical, dental, vision) insurance plan, for a maximum period of up to 6 months. The employee on leave is required to pay his/her portions of the premium contribution to the group health (medical, dental, vision) insurance plan during the leave period. If an employee is on Furlough status, he/she will not be responsible for his/her premium contribution to the group health coverage.

If you go on an unpaid leave that affects eligibility for before-tax elections under the Plan, then the election change rules described in the *Making Changes during the Year* section of this Document will apply.

This section describes benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Plan Administrator.

Family and medical leave

The federal Family and Medical Leave Act ("FMLA") allows eligible employees to take leave for certain reasons, including for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty.

See the Family and Medical Leave Act discussion in the *Making Changes during the Year* section and the *Continuation Coverage* section of this Document for more information on continuation of benefits during FMLA leave.

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your health coverage for up to 24 months (or the day you fail to return to work after the end of the leave if sooner) as long as you give the Company advance notice of the leave (with certain exceptions). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from the Company, can not exceed five years (with certain exceptions). There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit – including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after you uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave (including any amount for dependent coverage).

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period.

If you take a military leave, but your coverage under the health benefits program is terminated — for instance, because you do not elect the extended coverage — when you return to work at the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies.

All other coverages will continue during your military leave.

Participation in the dependent care FSA will terminate. If you are called to perform military service for more than 179 days, you will be able to take your unused health FSA balance as a taxable cash distribution by the last day of the FSA Plan Year, extended for any 2 ½ month grace period.

Funding

The Company's contributions

The Company will contribute to the cost of benefits provided under the Plan in whole or in part. Contributions made by the Company will be made at the times and in the manner determined by the Company. All contributions made by the Company will be for the exclusive purpose of providing benefits to you and other participants in the Plan. In no event shall the Company have any obligation to fund self-insured benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. The Company shall determine the method for funding benefits under the Plan. The method may include the purchase of insurance, contracting with HMOs or PPOs, payments from general assets, or through any combination of these methods or otherwise.

Your contributions

The amount of contributions that you will be required to make with respect to each program requiring an employee contribution will be set forth in the enrollment forms and/or benefit booklets. In determining required contributions, the Company may take into account such factors as the projected cost of insurance premiums, administrative fees and benefits under the Plan, the prior claims experience under the various benefits offered by the Plan, and the amount of the Company's contributions to the Plan. The Company's objective in determining the amount of required contributions shall be to provide sufficient funds to cover the projected cost of benefits available under the Plan equal to the combined total of the contributions required and the amount that the Company has agreed from time to time to contribute toward the cost of benefits. The Company will deduct contributions from your wages in accordance with the Company policies and the salary reduction or deduction agreements between the Company and you.

Source of benefit funding

The Company's general assets shall be the sole source of self-insured benefits under the Plan. No assets will be set aside for the purpose of providing benefits under the Plan. The Company shall pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of the Company, and benefits shall be deemed to come first from amounts contributed by employees and then from amounts contributed by the Company.

Unless otherwise required by applicable law, the Company assumes no liability or responsibility for payment of such benefits beyond that which is provided in the Plan, and each participant or other person who claims the right to any payment with respect to such benefits under the Plan shall not have any right, claim or demand therefore against the Company or any employee, officer or director of the Company.

With respect to insured benefits, you (or in the case of your death your beneficiary as that term is defined in the applicable insurance contract or booklet) will be entitled to receive only the insured benefit for which provision is actually made under the insurance contract or booklet. The Company does not assume liability or responsibility for any insured benefit and you will only be able to look to the insurance contracts for payment of any benefits. You will not have any claim for insured benefits against the Company, the Plan Administrator or any employee, officer or director of the Company. To the maximum extent that is consistent with ERISA or other applicable law, in the event of a conflict between the terms of an insurance contract and this Document, the terms of the insurance contract shall govern.

Policy dividends and refunds

To the fullest extent permitted by applicable law, the Company will be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, or other organizations, or any individual, that exceeds the amount necessary to fund the benefits provided by any particular benefit program offered under the Plan.

Experience gains

All amounts paid to and held by the Plan, as well as any policy dividends and refunds not belonging to the Company, will be available to fund the benefits provided by any benefit program. The Plan Administrator, in its exclusive discretion, may use funds accumulated under the Plan or any benefit program (whether insurance contract reserves, participant or Company contributions, or administrative fees) to reduce the level of contributions or payments of expenses or benefits that the Company would otherwise make to the Plan or any benefit program.

No right to assets

No participant or beneficiary will have any right to, interest in, or claim for, any assets of the Company, the Plan, any benefit program, or any underlying contract, trust or other vehicle for purposes of satisfying any benefits due such individual.

ERISA

Note that the pre-tax salary reduction elections under Code section125 (the cafeteria plan), the dependent care FSA, state-mandated STD, and the HSA component benefit programs are not covered by ERISA and this ERISA rights statement does not apply to these Programs.

As a participant in certain of the benefit programs, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive information about your plan and benefits

You can review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plans with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

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

Receive a summary of the plans' annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue group medical plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the medical plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary and the other documents governing the plans on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the medical plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage decreases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on 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 company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a 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 (if any) from the plans and do not receive them 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plans' 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 fiduciaries misuse the plans' assets, or if you are discriminated against for asserting your rights, you may seek assistance from the US 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 your claim is frivolous.

Assistance with your questions

If you have any questions about your plans, 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, US Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Plan Administration and Other General Information

The Company is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this document or in an insurance or administrative contract. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make certain amendments to the Plan to comply with law, to make determinations regarding issues that relate to eligibility for benefits, to decide disputes that may arise relative to a Plan Participant's or any other person's rights or obligations, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Company will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor the Company will be liable in any manner for any determination made in good faith.

The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court's 1989 decision in *Firestone Tire & Rubber Co. v. Bruch*.

The Company may designate other organizations or persons to carry out specific fiduciary responsibilities of the Company in administering the Plan including, but not limited to, the following:

- pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- the responsibility to act as a Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Company will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Power and authority of the insurance company

Certain benefits under these Plans are fully insured. Benefits may be provided under a group insurance contract entered into between the Company and an insurance company. With respect to fully insured benefits, claims for benefits should be sent to the insurance company. The insurance company is responsible for paying claims, not the Company.

The insurance company is responsible for:

- determining eligibility for and the amount of any benefits payable under the applicable benefit coverage.
- prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the applicable benefit coverage.

The insurance company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the applicable benefit coverage.

The Plan Administrator hereby delegates to each insurance company the discretionary authority to construe and interpret the terms and provisions of the insurance benefits they are contracted to provide as listed herein.

Questions

If you have any general questions regarding the Plan, or any benefit program offered under the plan, please contact the Plan Administrator.

Plan Information	
Plan Sponsor	T & M Associates 11 Tindall Road Middletown, NJ 07748-2717 732-671-6400
Employer Identification Number	22-1806708
Plan Administrator	T & M Associates 11 Tindall Road Middletown, NJ 07748-2717 732-671-6400
COBRA Administrator	Benefit Express 1700 E. Golf Road, Suite 1000 Schaumburg, IL 60173 877-837-5017
Health Savings Account (HSA)	(8/1/18-12/31/18) My Benefit Wallet P.O. Box 1584 Secaucus, NJ 07094 (877) 472-4200 https://mybenefitwallet.com/index.html (1/1/19-8/1/19) Further P.O. Box 64193 St. Paul, MN 55164-0193 (888) 215-0025 HorizonMyWay.CustomerSolutions@hellofurther.com Horizonblue.com (8/1/19-7/31/20) PayFlex 888-678-8242 www.payflex.com FlexFacts (Effective 8/1/20) www.flexfacts.com 877-943-2287

Bravo Wellness (Administrator Wellness Incentive Program)	Bravo Wellness One International Place 20445 Emerald Parkway Dr. SW, Suite 400 Cleveland, OH 44135 877-662-7286 support@bravowell.com www.bravowell.com/tmassociates
Claims Administrators	See charts below
Agent for Service of Legal Process	Plan Administrator
Plan Year	August 1 to July 31

Coverage Period	Elections under the Plan are made based on the following coverage periods: Health FSA and Dependent Care FSA – January 1 through December 31 All other Plans – August 1 through July 31
Participating Employer	East Coast Drilling (January 2005) 20-2077539 11 Tindall Road Middletown, NJ 07748 732-865-9617

Plan Types, Names and Numbers	

- Medical (including prescription drug)
- Health Savings Account (HSA)
- Dental
- Vision
- Life Insurance Benefits
  ♦ Basic Life
  ♦ Voluntary Life
  ♦ Dependent Life
- Accidental Death and Dismemberment (AD&D)
  ♦ Basic AD&D
  ♦ Voluntary AD&D
  ♦ Dependent AD&D
- Short Term Disability (STD) (NJ Employees Only)
- Voluntary STD
- Long Term Disability (LTD)
- Voluntary LTD
- Employee Assistance Program (EAP)
- Health Flexible Spending Account (FSA)
- Dependent Care FSA
- Voluntary Personal Accident
- Voluntary Cancer
- Voluntary Specified Health Event
	T & M Associates Employee Welfare Plan
	Plan Number 502

The dependent care FSA, health savings account (HSA) , state-mandated STD, and the pre-tax salary reduction elections under Code section125 (the cafeteria plan) described herein are not subject to ERISA.

Claims Administrators	
Self-Insured Plans: *The following benefits are self-insured by the Company through contributions made by the Company, or contributions made jointly by the Company and participating employees. These benefits are paid directly out of the general assets of the Company. There is no special fund or trust from which benefits are paid. The Company has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for self-funded benefits may be retained by the Company or delegated to the Claims Administrator. Any such delegation of this ERISA fiduciary responsibility to the Claims Administrator will be set forth in the associated documents which describe the benefit program:*	
Medical	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199

Prescription Drug	Express Scripts 1 Express Way St. Louis, MO 63121 (844) 433-4882 www.express-scripts.com
Dental	Delta Dental of New Jersey 1639 Route 10 Parsippany, NJ 07054 800-452-9310 www.deltadentalnj.com
Insured Plans: *The following benefits are insured through contracts with insurance companies who also administer claims for these benefits and are solely responsible for providing benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for fully insured benefits is delegated to the insurance companies:*	
Vision	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195 www.vsp.com
Voluntary STD Long Term Disability (LTD) Voluntary LTD	Provident Life and Accident Insurance Company 2211 Congress Street Portland, ME 04122 800-421-0344 www.unum.com
Basic Life Basic Accidental Death & Dismemberment (AD&D) Voluntary Life and AD&D Dependent Life and AD&D	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 800-421-0344 www.unum.com
Employee Assistance Plan (EAP)	CareBridge 800-437-0911 clientservice@carebridge.com www.myliferesource.com access code: HXJ4X
Health Flexible Spending Account (FSA) Dependent Care FSA	Benefit Express P. O. Box 189 Arlington Heights, IL 60006 877-837-5017
Voluntary Personal Accident Voluntary Cancer Voluntary Specified Health Event	Aflac Worldwide Headquarters 1932 Wynnton Road Columbus, GA 31999 800-992-3522

Plan amendment and termination

The Company reserves the right to amend the Plan, as set forth in this document, in whole or in part, to completely discontinue any of the benefit programs, and to terminate the Plan in its entirety, at any time. For example, the Company reserves the right to amend or terminate covered expenses, benefit co-pays, lifetime maximums, and reserves the right to amend the plans to require or increase employee contributions. The Company also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by the Company with respect to the Plan shall be by a duly adopted resolution of the Board of Directors or may be made by any person duly authorized to take such action on behalf of the Board of Directors. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination. In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan shall terminate unless the Plan is continued by a successor to the Company.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Company to the extent permitted under applicable law, unless otherwise stated in the insurance or administrative contract or otherwise determined by the Board of Directors of the Company.

Participating employers

Any Affiliated Company may, with the consent of the Company, become a Participating Employer under the Plan, provided the Participating Employer agrees to be bound by all of the provisions of the Plan and any amendments in the manner set forth herein, agrees to pay its share of the expenses of the Plan as they may be determined from time to time; and agrees to provide the Company with full, complete, and timely information on all matters necessary for the operation of the Plan. "Affiliated Company" means all corporations and other entities which are members of the Company's controlled group or are under common control with the Company (within the meaning of Section 414 of the Code), but only during the period any such corporation or other entity is a member of such controlled group or under such common control.

In the event of the adoption of the Plan by an Affiliated Company, the Affiliated Company shall become a Participating Employer and all the terms and conditions of the Plan as set forth hereunder shall apply to the participation under the Plan of such Affiliated Company and its Employees. Notwithstanding the above, the Company reserves the right to designate a Participating Employer and the right to amend the Plan, as set forth herein. These rights are specifically reserved to the Company so long as the Participating Employer participates under the Plan; and any such amendment, unless otherwise specified therein, shall be fully binding with respect to such participation by any Participating Employer; provided that this reservation shall in no event be construed to prevent any Participating Employer from terminating at any time its participation as a Participating Employer under the Plan.

The Company, in its sole and absolute discretion, may allow any Participating Employer at any time to terminate its participation under the Plan; provided that, if the Company shall terminate its participation in the Plan, or disassociate itself, then each remaining Participating Employer shall make such arrangements and take such action as may be necessary to assume the duties of the Company in providing for the operation and continued administration of the Plan.

Other Important Information

SPD/Plan Document

This Document constitutes the T & M Associates Employee Welfare Plan and is an amendment and restatement of the Plan effective as of August 1, 2018. The Company maintains the Plan for the exclusive benefit of its eligible employees and their eligible spouses and dependents. The Plan provides benefits through the component benefit programs described herein. Each of these component programs is described in a contract, certificate or booklet issued by an insurance company, a plan summary, or another governing document prepared by the Company or vendor for the benefits listed herein. A copy of each applicable component document is attached to this Plan. This Document should be read in combination with the certificates of insurance and benefit booklets, which are incorporated by reference into this Document. The Plan, through this Document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") A separate Cafeteria Plan document is incorporated by reference in this Plan and is intended to satisfy the written document requirements of the Internal Revenue Code with respect to those benefits.

No assignment of benefits

Except as may otherwise be required by applicable law, or as otherwise specifically provided in the Plan or by certificates of insurance and benefit booklets, you will not be entitled to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse or any dependents at any time under the Plan. Any attempt to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse or dependent attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, then the Plan Administrator, if it so elects, may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper.

Notwithstanding the foregoing provisions of this *No assignment of benefits* section, you may request and authorize the Plan Administrator or the appropriate insurance company or service provider to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable benefit program and any such payment, if made, shall constitute a complete discharge of the liability of the plan therefore. Benefits also may be assigned to an alternate recipient pursuant to a QMCSO.

Medicaid eligibility and assignment of rights

The Plan will not take into account whether an individual is eligible for, or is currently receiving medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to §1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under the Plan.

Important legal notice

The Plan Administrator will be responsible for the general administration of the Plan. The Plan Administrator and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, will have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising

in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator will be final and binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Waiver of terms

No term, condition or provision of the Plan shall be deemed waived, and the provisions of the Plan will be enforced, unless the Company or you specifically waive in writing the condition or provision. The written waiver will not be deemed a continuing waiver unless stated specifically in the waiver, and each waiver will operate only as to the specific term or condition waived.

Excess payments

If the Plan has made an erroneous or excess payment to or on behalf of you, your spouse or dependents, the Plan Administrator shall be entitled to take action to correct the error, including recovering the excess from you, your spouse or dependents. To the extent permitted by applicable law, the recovery of the overpayment may be made by offsetting the amount of any other benefit or amount payable to or on behalf of you, your spouse or dependents by the amount of the overpayment.

Limitation of rights

This Document will not be held or construed to give any person any legal or equitable right against the Company, the Plan Administrator, or any other person connected with the Company or the Plan, except as expressly provided in this Document or as provided by applicable law; or to give any person any legal or equitable right to any assets of the Plan.

Severability

If any provision of this Document is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provision of this Document. The Document shall be construed and enforced as if such provision had not been included in this Document.

Tax consequences

The Company does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in the Plan. You should consult with professional tax advisors to determine the tax consequences of participation.

Misrepresentation or fraud

If you receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and you may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator will decide such matters on a case by case basis. You may be asked to provide proof of eligibility for your dependents. False or misrepresented eligibility information could cause both your and your dependents coverage to terminate irrevocably (retroactively, to the extent permitted by law), and could be grounds for disciplinary action, up to and including your termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Legal action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Applicable law

This Document shall be construed in accordance with the laws of the State of New Jersey, except to the extent such laws are pre-empted by the law of any other state or by federal law.

Paperless communications

Notwithstanding anything contained in this Document to the contrary, the Company may from time to time establish uniform procedures whereby with respect to any or all instances in this Document where a writing is required, including but not limited to any required written notice, election, consent, authorization, instruction, direction, designation, request or claim communication may be made by any other means designated by the Company, including paperless communication, and such alternative communication shall be deemed to constitute a writing to the extent permitted by applicable law, provided that such alternative communication is carried out in accordance with such procedures in effect at such time.

HIPAA Privacy and Security

This section describes the manner in which the Plan will protect certain health information used or maintained by the Plan.

The Company sponsors and maintains certain group health plans that are subject to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") regulations as are described more fully in this Document. Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), and as HIPPA and the HIPPA regulations were amended by the American Recovery and Reinvestment Act of 2009 ("ARRA"), a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce;

1. **Uses and Disclosures of PHI.** The Plan and the Company may disclose a Plan participant's PHI to the Company (or to the Company's agent) for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.

2. **Restriction on Plan Disclosure to the Company.** Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan's receipt of the Company certification that the Plan has been amended to incorporate the agreements of the Company under paragraph 3, except as otherwise permitted or required by law.

3. **Privacy Agreements of the Company.** As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

   a. Not use or further disclose such PHI other than as permitted by paragraph 1 of this section, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

   b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;

   c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, and not use or disclose PHI that is genetic information for underwriting purposes;

   d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

   e. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

   f. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Company pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

   g. Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

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

i. Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

(1) ***Employees With Access to PHI*:** The following employees or other individuals under the control of the Company are the only individuals that may access PHI received from the Plan: Human Resources Manager, Benefits Administrator, and Chief Financial Operating Officer.

(2) ***Use Limited to Plan Administration***: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

(3) ***Mechanism for Resolving Noncompliance*.** If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this section, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

j. Notify a participant or participants of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

(1) the names of the individuals whose PHI was involved in the Breach;

(2) the circumstances surrounding the Breach;

(3) the date of the Breach and the date of its discovery;

(4) the information Breached;

(5) any steps the impacted individuals should take to protect themselves;

(6) the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

(7) a contact person who can provide additional information about the Breach.

The Company will cooperate with you in the investigation of, and response to, the Breaches it reports to you. For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

4. **Security Agreements of the Company**. As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 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;

d. Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, "Security Incident" shall mean successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

e. Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

5. **PHI not Subject to this Section**. Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 4 above shall apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1)

6. **Definitions**. All capitalized terms within this section not otherwise defined by the provisions of this section shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

Appendix A: Summary Plan Description Attachments

This Appendix is considered a part of the Plan and may be amended by the Company at any time for any reason without consent of any person except as otherwise provided by applicable law. Formal amendment of the Plan is not necessary to amend this Appendix. It may be amended by adding a new Appendix with the current date and current listing of incorporated documents.

The following benefits are further described in summaries and booklets which will be provided to participants as attachments to this Document upon request. The terms, conditions and limitations of the benefits are set forth in the Plan and the underlying incorporated documents referenced herein. Certain documents are incorporated by reference in this Appendix, including any written document pursuant to which the applicable benefit is provided under the Plan (e.g., written plans, vendor contracts, insurance policies, coverage certificates, summary plan descriptions, or other materials describing benefits provided thereunder).

The following Plan benefits are further described in summaries and booklets attached to this Document:

- Medical (including prescription drug)
- Health Savings Account (HSA)
- Employee Assistance Plan (EAP)
- Vision
- Dental
- Life Insurance and Accidental Death & Dismemberment (AD&D)
- Voluntary Life and AD&D
- Dependent Life and AD&D
- Long Term Disability (LTD)
- Voluntary LTD
- Short Term Disability (STD) (NJ Employees Only)
- Voluntary STD
- Health Flexible Spending Account (FSA)
- Dependent Care FSA
- Voluntary Personal Accident
- Voluntary Cancer
- Voluntary Specified Health Event
- Wellness Incentive Program

Appendix B: Participating in Benefits Attachments

The benefits indicated below and described in this document are available to certain current employees of the Company and their eligible dependents, as applicable and as further described below.

An eligible employee with respect to the Plan is any common-law employee of the Company who is eligible to participate in and receive benefits under one or more of the component benefit programs. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the attachments for the applicable component benefit programs. A general summary of this information is set forth below.

Eligibility

Employee[1] Coverage

Benefit Program	Eligibility Requirements*

- Medical (including prescription drug)
- Dental
- Vision
- Employee Assistance Plan (EAP)
- Pre-tax Salary Reduction Elections
- Life Insurance Benefits
  ♦ Basic Life
  ♦ Voluntary Life
  ♦ Dependent Life
- Accidental Death and Dismemberment (AD&D)
  ♦ Basic AD&D
  ♦ Voluntary AD&D
  ♦ Dependent AD&D
- Short Term Disability (STD) (NJ Employees Only)
- Voluntary STD
- Long Term Disability (LTD)
- Voluntary LTD
- Health Flexible Spending Account (FSA)
- Dependent Care FSA
- Voluntary Personal Accident
- Voluntary Cancer
- Voluntary Specified Health Event
	Full-time eligible employees regularly scheduled to work at least 30 hours per week are eligible to participate on the first day of the calendar month following date of hire.
	
	Part-time eligible employees working at least 20 hours in the following classes are eligible to participate on the first day of the calendar month following date of hire:
	
	• Business Development Representatives
	• Client Managers

*Except as required by any state law for employees enrolled in insured plans with policies issued in that state.

Certain individuals or groups are included in participation or excluded from participation in certain or all of the benefits offered under the Plan as determined by the Company. For example, individuals who are characterized by the Company as an independent contractor or a contract employee, are excluded from

[1] Employee means a common law employee of the Company. The term employee does not mean any of the following persons, even if determined retroactively by a court or governmental agency to be a common law employee: a self employed individual as defined in Code section 401(c)(1)(A), a member of the Board of Directors who is not otherwise an employee, a person the Plan Administrator determines is an independent contractor for the Company, and a person the Plan Administrator determines is engaged by the Company as a consultant or advisor on a retainer or fee basis. A person the Plan Administrator determines is not an "employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

participation. This summary provides no guarantee that you are eligible to participate in every benefit or program described herein. For additional information regarding eligibility under the programs, please contact the Plan Administrator.

The following individuals may not participate in the Plan:

- commissioned employees;
- part-time employees defined as employees who are regularly scheduled to work less than 20 hours per week, and part time employees working 20 – 30 hours per week that are not in the Business Development Representative or Client Manager classes
- leased workers as defined in Code Section 414(n);
- those characterized by the Company as independent contractors;
- temporary employees defined as employees who are project based,
- seasonal employees defined as employees who are co-ops and college interns;
- non-resident aliens who received no income (within the meaning of Code Section 911(d)(2)) from an employer that constitutes income from sources within the United States, as defined in code Section 861(a)(3); and
- employees not eligible under Employer's group medical plan.

Spousal coverage

If you are eligible to receive medical, dental or vision benefits under the Plan, your spouse will also be eligible to receive these benefits if coverage is elected. For purposes of these benefit programs, your eligible spouse means your spouse (same or opposite sex) under a legally valid marriage. Divorced spouses are not eligible for continued coverage under the Plan.

For purposes of these benefit programs, your eligible spouse means your spouse (same or opposite sex) under a legally valid. Divorced spouses are not eligible for continued coverage under the plan.

Note too that the definition of covered spouse may vary under certain fully-insured programs offered in certain states - refer to the certificates to identify a "spouse" covered under a particular insured contract. Spouses are also eligible to receive Dependent Life benefits if elected.

Dependent children

If you are eligible to receive benefits under the medical, dental, or vision benefits program, your or your spouse's dependent children may also be eligible to receive these benefits if coverage is elected. Dependent children are also eligible to receive Dependent Life Benefits if elected.

For purposes of these benefits, your dependent children are your or your spouse's:

- natural children,
- step children,
- legally adopted children;
- children who are placed in your home for adoption,
- children under your legal guardianship, who are primarily supported by you, and
- children that the Plan is required to cover under the terms of a Qualified Medical Child Support Order ("QMCSO").

A dependent child will be eligible to participate if he/she is:

- a covered employee's children up to age 26 regardless of student status, marital status, financial dependence or residence (health benefit/prescription drug and dental coverage);
- a dependent child who was covered under the Plan prior to reaching the age of twenty-six (26) years and who lives with the employee, is unmarried, incapable of self-sustaining employment and dependent upon the employee for support due to a mental and/or physical disability, will remain eligible for coverage under this Plan beyond the date coverage would otherwise terminate. Proof of incapacitation must be provided within sixty (60) days of the child's loss of eligibility and thereafter

as requested by the employer or claims processor, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the cessation of the mental and/or physical disability, and failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Note: Please review your fully-insured program materials for each benefit carefully. These fully-insured programs may have different eligibility requirements for dependents. For example, some insured coverages may have different age limits or requirements or limitations for insuring dependent children.

Please refer to your insured coverage booklet for more information. Note too that if insured group health coverage is available for your adult child under state law, such benefits may not be available on a pre-tax basis under federal tax law.

The following dependents are eligible for coverage under the dependent life benefit:

- your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.
- your unmarried children from live birth but less than age 26. Stillborn children are not eligible for coverage.
- children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No Dual Coverage Permitted

If you are married to another employee of the Company, you may enroll as an employee or as a dependent, but you cannot be covered as both. Dependent children may be covered under one employee's coverage only.

Application of Health Care Reform

For certain companies with 50 or more full-time Employees, the number of hours worked to obtain full-time status for group health plan coverage purposes will be determined in accordance with certain measurement rules adopted by the Company for all Employees (including variable hour and seasonal employees, if such classes exist within the Company). A temporary Employee is not eligible for coverage if he or she is eligible for health coverage through a leasing company, unless otherwise required by Health Care Reform and the Company. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations. This eligibility information is available upon request to the Plan Administrator.

If the Company utilizes the measurement rules under the "look-back" method as permitted by Health Care Reform, each Employee's hours of service in a prior period (called the "measurement period") will be calculated to determine the status of the Employee during a future period (called the "stability period"). The Company may also utilize an additional time period (called the "administrative period"), between the measurement period and the stability period, to complete administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. Employees whose hours are variable or otherwise uncertain at their start dates (e.g., "variable hour" or "seasonal" Employees) will not initially be eligible for coverage during the applicable measurement period. If it is determined during the measurement period (and any associated administrative period, if applicable) that such Employees are considered to be full-time, they will be offered coverage during their subsequent stability period.

"**Administrative Period**" means a period of 31 days beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days.

"**Employee**" means an individual who is employed by an Employer and regularly scheduled to work at least 30 hours per week or 130 hours per month (non-variable hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week or 130 hours per month for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Administrator. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

"**Initial Measurement Period**" means, for a newly hired Variable Hour Employee, the Measurement Period starting from the date of hire and ending after 12 consecutive months of service.

"**Measurement Period**" means a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine his or her employment status for benefit purposes.

"**Ongoing Employee**" means an Employee who has been employed by the Employer for at least one complete Measurement Period.

"**Stability Period**" means a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is the remainder of the year after the end of the Administrative Period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

"**Standard Measurement Period**" means, for Ongoing Employees, the period that starts 8/1 each year and will last for 12 consecutive months.

T&M Associates Employee Welfare Plan

Summary Plan Description and Plan Document

Plan Amendment and Summary of Material Modification

WHEREAS, T&M Associates (the “Company”) has established and presently maintains the T&M Associates Employee Welfare Plan Summary Plan Description and Plan Document Amended and restated effective August 1, 2018 with amendments through July 31, 2021 (the "Plan"), for the benefit of its eligible employees and eligible spouses, and dependents; and

WHEREAS, the Company wishes to amend the Plan, effective January 1, 2023, to provide that for medical (including prescription drug), dental and vision coverage under the Plan, coverage for dependent child(ren) will end as of the last day of the calendar year in which the dependent child(ren) turns 26.

WHEREAS, the Company intends this document to act as the Summary of Material Modification (“SMM”) to be shared with Plan participants and which modifies the information contained in the Summary Plan Description (“SPD”) for the Plan.

NOW, THEREFORE, BE IT RESOLVED, that the *When Coverage Ends* section of the Plan is amended by replacing the second paragraph therein with the following:

Except as otherwise provided under a plan specific summary or evidence of coverage booklet, your eligible dependent’s coverage automatically will terminate on the earliest of the following dates:

- the date the Plan terminates;
- the date a particular benefit program terminates (for that benefit program only);
- the date on which your coverage terminates;
- the date you elect to terminate your eligible dependent’s coverage;
- the last day for which the necessary contributions are made;
- with respect to medical (including prescription drug), dental and vision coverage, flexible spending accounts, the last day of the month in which the eligible dependent(s) ceases to be eligible for coverage, and the last day of the calendar year in which the eligible dependent(s) ceases to be eligible for coverage due to turning 26 during the year;
- with respect to life Insurance and accidental death & dismemberment insurance, and voluntary benefits coverage, on the birth date in which the eligible dependent(s) ceases to be eligible for coverage;
- the date the eligible dependent(s) is covered as an employee under the Plan;
- the date the eligible dependent(s) is covered as the dependent of another employee under the Plan;
- the date the eligible dependent(s) enters the armed forces of any country or international organization; or
- the date the dependent is no longer eligible for coverage under a qualified medical child support order (QMCSO).

FURTHER RESOLVED, that the adoption of the Plan amendment as described herein shall be, and hereby is, affirmed, ratified, and be it

FURTHER RESOLVED, that the appropriate officers be and each of them hereby is, authorized and empowered, on behalf of the Company and in its name, to make all such arrangements, to do and perform all such acts and things, and to execute and deliver all such instruments and documents as they may deem necessary or appropriate in order to effectuate fully the purpose of each and all of the foregoing resolutions.

IN WITNESS WHEREOF, the undersigned has executed this document the 22 day of December 2022.

Lynn Spence

Lynn Spence, SVP, Chief People Officer

AMENDMENT NO. 2

T&M Associates, Inc.
Employee Welfare Plan

Effective August 1, 2024, the T&M Associates, Inc. Employee Welfare Plan (the "Plan") is hereby amended in the following particulars. All other sections of the Plan remain unchanged.

1. In the **CONTINUATION COVERAGE** section, references to Benefit Express as the COBRA Administrator are removed and replaced with the following:

   Benefit Allocation Systems
   800-945-5513

2. In the **PLAN ADMINISTRATION AND OTHER GENERAL INFORMATION** section, references to WEX as the COBRA Administrator are removed and replaced with the following:

COBRA Administrator	Benefit Allocation Systems 800-945-5513

3. In the **PLAN ADMINISTRATION AND OTHER GENERAL INFORMATION** section, references to Bravo Wellness as the administrator of the Wellness Incentive Program are removed and replaced with the following:

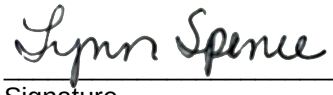
WellWorks for You (Administrator Wellness Incentive Program)	WellWorks for You 800-425-4657

4. In the **PLAN ADMINISTRATION AND OTHER GENERAL INFORMATION** section, references to Express Scripts as the prescription drug claims administrator are removed and replaced with the following:

Prescription Drug	Smith Rx 844-454-5201

All other sections of the Plan remain unchanged.

APPROVED AND ACCEPTED

By: 
Signature

Title: _SVP, Chief People Officer_____

Date: _September 25, 2024_____