Asahi Kasei North America
Health & Welfare Benefits Plan

Plan No. 502

WRAP PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

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INTRODUCTION
Asahi Kasei Plastics North America, Inc. ("the Company") sponsors the Asahi Kasei North America Health & Welfare Benefits Plan ("the Plan") for your benefit and the benefit of your family, if you are an eligible employee of the Company. The term “Company” also will include any affiliates and subsidiaries of the Company (within the meaning of Internal Revenue Code Section 414(t)) who are authorized in writing to participate in the Plan by Asahi Kasei Plastics North America, Inc. (collectively referred to as “Company” throughout this document and identified in Appendix A); provided, however, that whenever the Plan indicates that the Company may or shall take any action under the Plan, Asahi Kasei Plastics North America, Inc. shall have sole authority to take such action for itself and as agent for any such related entity.

The Plan provides benefits through the following component benefit programs:

- Medical
- Prescription Drug
- Dental
- Vision
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account
- Pre-Tax Payment Program
- Short Term Disability
- Long Term Disability
- Life and Accidental Death and Dismemberment
- Employee Assistance Program

Each component benefit program offered under the Plan has its own eligibility requirements. If you meet the eligibility requirements for a benefit program, the Plan allows you to participate in that program. Please note that not all of the options listed above may be available to you as the Company’s benefit offerings are different for some locations. The Company will let you know which programs are available to your employee group at the time of your enrollment (see also Appendix B).

Some of the benefit programs are self-funded by the Company. That means the Company pays for the benefits from its general assets. Other benefit programs are insured. That means the Company pays premiums to insurance companies, and the insurance companies pay benefits under an insurance policy or contract. Appendix A indicates whether a benefit program is self-funded or insured.

This wrap document has been prepared to comply with various disclosure requirements mandated by law, to clarify administrative procedures for and clarify eligibility conditions under each of the component benefit programs, and to join the welfare benefit programs together into a single legal wrap plan document for annual reporting purposes (collectively referred to as the “Plan”).

Each component benefit program listed above has its own separately written benefit program booklet. Specifically, for fully-insured benefit programs, the insurer will provide an insurance policy and summaries of coverage. For self-funded benefit programs, the Company and/or its delegated third party administrator will prepare a benefit program booklet. These benefit program booklets generally specify the terms and conditions to receive benefits, including an explanation of covered and excluded benefits (e.g. schedule of benefits), cost-sharing requirements, network requirements, and contact information.
regarding the insurer or third party administrator, etc. Together, this wrap plan document and the benefit program booklet for each component benefit program constitute the combined written instrument (within the meaning of Section 402(a) of ERISA) and summary plan description for the Plan.

YOU SHOULD NOT RELY ON ANY ORAL EXPLANATIONS, DESCRIPTION, OR INTERPRETATION OF THE PLAN BY ANY EMPLOYEE OF THE COMPANY OR THE COMPANY BECAUSE THE WRITTEN TERMS OF THE PLAN ALWAYS WILL GOVERN.

The component benefit programs generally are considered employee welfare benefit plans subject to and governed by Employee Retirement Income Security Act of 1974 (“ERISA”), except for the Cafeteria Plan, the Dependent Care Spending Plan, the Health Savings Account and the self-funded Short Term Disability Plan (which are considered payroll practices governed by the Internal Revenue Code and state law).

The Plan Administrator will furnish to you a copy of this wrap plan document as well as the benefit program booklets for a particular component benefit program when you first become a Participant in such program. You may obtain another copy of such documents at any time by contacting the Plan Administrator. You also may examine all of these documents in the Plan Administrator’s office, and may request a copy of such documents, but may be asked to pay for copying costs in some circumstances.

If you have any questions about the benefit programs or the Plan in general, please contact Human Resources at (800) 444-4408.

The Company expressly reserves the right to amend or revise any term or provision of the Plan or to terminate the Plan at any time in its sole discretion by action of the Company’s governing board.

PLAN ADMINISTRATION

The Company is the Plan Administrator and has sole responsibility for the administration of the Plan. The Human Resources Director has been designated to act on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Plan Administrator has full discretionary authority to:

- Interpret the Plan;
- Determine eligibility for and the amount of benefits;
- Determine the status and rights of participants, beneficiaries and other persons;
- Make rulings;
- Make regulations and prescribe procedures;
- Gather needed information;
-Prescribe forms (including the enrollment form);
- Exercise all of the authority contemplated by ERISA and the Code with respect to the Plan;
- Employ or appoint persons to help or advise in any administrative functions; and
- Generally, do anything needed to operate, manage and administer the Plan.
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 Plan has other fiduciaries, advisors and/or service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Delegates shall possess the full extent of the Plan Administrator’s authority and duties with respect to those responsibilities delegated to them. Any allocation or delegation must be done in writing and kept with the records of the Plan.

For the insured benefit programs, the Plan Administrator, where indicated in Appendix A, delegates its fiduciary duties with respect to claims processing and initial and final claims determinations to the insurers, as Claims Administrators.

For the self-funded benefit programs, the Plan Administrator, where indicated in Appendix A, delegates its fiduciary duties with respect to claims processing and initial claims determination and, in some cases, final claims determinations, to third-party service providers, as Claims Administrators. These third-party Claims Administrators do not insure that any benefit program benefits will be paid.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being a fiduciary.

**PLAN FUNDING**

The Company pays all or part of the cost of some benefit programs. You are responsible for paying all or a part of the cost of some benefit programs through your benefit contributions (see Appendix A). The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. The Company also may establish a Cafeteria Plan under Internal Revenue Code Section 125 permitting you to pay your share of premiums or employee contributions through pre-tax payroll deductions. You also are responsible for any deductible, copayment, and coinsurance that may be required under the terms of the benefit programs.

The benefits provided under the Plan will be paid, to the extent permitted under ERISA and the Internal Revenue Code, from the general assets of the Company, employee contributions, and insurance contracts. Nothing in this Plan will be construed to require the Company to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any participant, and no participant or other person will have any claim against, right to, or security or other interest in, any fund account or asset of the Company from which any payment under the Plan may be made.

Individuals covered under the Plan’s self-funded benefit programs are not insured. For those benefit programs that are self-funded, if you are covered by this Plan and either the Plan or the Company does not ultimately pay the expenses that are eligible for payment under the Plan for any reason, you and your covered dependents may be personally liable for those expenses.

The Claims Administrator under any self-funded component benefit program merely processes claims and does not ensure that any of your expenses will be paid. Complete and proper claims for benefits made by you will be promptly processed; but if there are delays in processing claims, you shall have no greater rights against the Claims Administrator than are otherwise afforded you by law.
ELIGIBILITY

Employee Eligibility

An eligible employee with respect to the Plan will be any common-law employee of the Company who is designated by the Company as regularly scheduled to work at least 30 hours per week and is eligible to participate in and receive benefits under one or more of the component benefit programs; provided, however that the following individuals will not be eligible:

- any individual for whom the Company designates as an independent contractor or leased or contract employee (regardless of the finding by the Company or any third party as to the common law employment status or reclassification of any such person); or

- any individual classified by the Company as an intern or contingent employee, as a seasonal employee regularly scheduled to work fewer than 6 consecutive months during plan year or as a part-time employee regularly scheduled to work less than 30 hours a week.

To determine whether you are eligible to participate in the benefits provided under the Plan, please read the eligibility information contained in each of the component benefit program booklets. Some of the carrier booklets do not specify employee eligibility information. This information is listed in Appendix B.

Various employee groups (e.g. certain locations/facilities) may receive different coverage, may be ineligible for or only have certain benefit options available to them under the health and welfare programs described in this document. As a result, the component benefit booklets may differ from one employee group to another. The Company will provide you with a copy of the booklets that pertain to your employee group and the Benefit Enrollment Guide and Appendix B for your employee group will describe the choices available to you for the Plan Year.

If you initially are not considered by the Company to be an eligible employee, but are later determined to be an eligible employee, you only will be eligible prospectively from the date of that determination.

Dependent Eligibility

You also may be eligible to enroll your dependents for coverage to the extent permitted under the component benefit program booklet. However, you must be covered by the applicable Plan, as an eligible employee, before any eligible dependent’s coverage will take effect. If you timely elect dependent coverage, their coverage generally begins on the same date your coverage begins as specified in the benefit program booklet. No person may be covered as both an eligible employee and an eligible dependent and no person may be covered as an eligible dependent by more than one eligible employee. Please read the applicable benefit program booklet carefully to determine whether your dependent is eligible for coverage under the Plan. Such booklet or the Company’s policies may provide that your dependent (e.g. spouse) may only be covered under this Plan if he or she does not otherwise have coverage available through another group health plan or that a spousal surcharge may apply. Notwithstanding anything to the contrary in the benefit program booklet, the market reform provisions under the Health Care Reform Act regarding the continued eligibility of children until age 26 may apply to certain medical plan options (see below for more information under Health Care Reform Act section).

The Plan Administrator has full and final discretion to determine if, and require you to verify that, a dependent satisfies the eligibility requirements of the Plan, and to determine whether a dependent has been timely enrolled in the manner which satisfies Plan requirements. In this regard, the Plan Administrator may require that you submit documentation to verify the relationships of the dependents whom you wish to enroll. The Plan Administrator will notify you of any dependent verification
procedures. You also must notify the Plan Administrator within 30 days of any change to dependent’s qualification (e.g. attainment of limiting age, disabled status, etc). Failure to timely notify the Plan Administrator within 30 days of a change may result in disciplinary action up to and including termination of employment and loss of your benefit coverage under the Plan.

To the extent permitted under law (regarding the Health Care Reform Act’s restrictions on rescinding group health coverage), the Plan Administrator retains the right to retroactively or prospectively terminate coverage of a dependent as of the date that he or she no longer satisfies each of the Plan’s eligibility requirements and receive reimbursement from you or a dependent for any benefits that the Plan pays for a dependent who does not satisfy the Plan’s eligibility requirements.

Note Regarding Tax Rules for Dependents: In order for coverage under a group health plan option to be provided on a tax-free basis, your eligible dependent must be your spouse as defined under federal law or tax dependent as defined by the Internal Revenue Code Section 152 ((without regard to the earnings limit under §152(d)(1)(B); the special exclusions under §152(b)(1) or (2); or the age or student status requirements under §152(c)(3), provided that such dependent is age 26 or under during the entire Plan Year). If a covered eligible dependent (as defined in the benefit program booklet) does not qualify as your tax dependent or spouse (as defined under federal law), you cannot pay any required contributions for such dependent’s coverage on a pre-tax basis. Further, the value of the Company-paid portion for such dependent’s coverage must be added to your taxable income.

Qualified Medical Child Support Order
The Plan Administrator will honor an order which is a Qualified Medical Child Support Order (QMCSO) within the meaning of ERISA §609(a). The Plan Administrator has established procedures for determining whether a medical child support order is a QMCSO and for administering the provision of health benefits under the Plan pursuant to a valid QMCSO. A copy of the procedures can be obtained, without charge, from the Plan Administrator. The Plan Administrator has full discretionary authority to determine whether a medical child support order is “qualified” within the meaning of ERISA §609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

PARTICIPATION REQUIREMENTS
Certain component benefit programs require that you make an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found within the component benefit program booklets or in the Company’s annual enrollment materials. If you are an eligible employee, you may begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program.

Enrollment
You enroll in the Plan’s benefit programs and make changes to your benefit program elections by completing the enrollment forms for each program and timely submitting the completed forms to Human Resources. The “enrollment form” for a particular benefit program may include not only a paper form, but also any online, internet based form made available or required by the Company. All changes to your existing benefit program elections, or new benefit program elections, must also be submitted to Human Resources using the enrollment form made available or required by the Company.
Initial Enrollment Period

As a newly hired employee of the Company, you will be able to participate in the Plan when you meet the eligibility requirements of the component benefit programs, as long as you complete and return the enrollment forms to Human Resources and complete the enrollment process by the communicated due date. If you timely complete the enrollment process in the manner and by the deadline established by the Plan Administrator, coverage (for you and your properly enrolled Eligible Dependents) will begin effective as of the date specified in the components benefit program booklet and Appendix B.

Except as otherwise required by HIPAA, you typically must be actively at work on that date your coverage first becomes effective. When enrolling, if the Plan offers you the choice among various benefit options, you must select the option in which you and your Eligible Dependents will participate. You also must agree to pay any required contributions for your coverage. Your enrollment materials will specify these options. If you are an Eligible Employee who was previously enrolled in the Plan, terminate employment but then return to employment within 12 months as an Eligible Employee, you do no need to complete the applicable waiting period. If you are an Eligible Employee who was previously enrolled in the Plan, terminate employment but then return to employment as an Eligible Employee, you must complete the applicable waiting period (e.g. first day of month following 30 days of reemployment) before you will become eligible to reenroll in the Plan; provided however, that:

- **If you are reemployed within 30 days** in which you terminated, you will receive the same coverage you had when your employment ended; and
- **If you are reemployed after 30 days** in which you terminated, you will have the opportunity to elect new coverage options.

Annual Enrollment Period

Each year, the Company establishes an “Annual Enrollment Period.” During the Annual Enrollment Period, you can change your existing benefit program elections for the upcoming plan year (subject to the terms of the component benefit programs) by completing the applicable enrollment forms and submitting them to Human Resources by the communicated due date.

The benefit program elections you make under the Plan during the Annual Enrollment Period will take effect on January 1 and will remain in effect through December 31. You cannot change your benefit program elections during the period, unless you have a Special Annual Enrollment Period or you experience an eligible change event.

If you are eligible to participate in the Plan, and the Annual Enrollment Period falls during a time when you are on a leave of absence, the Company will provide you with election forms for the benefit programs.

HIPAA Special Enrollment Periods

Under certain circumstances, you and your covered dependents may change your health benefit program elections outside of the Annual Enrollment Period (a “Special Enrollment Period”). To determine which health plan benefit programs have Special Enrollment Periods, please refer to the component benefit program booklets. The HIPAA Special Enrollment Periods arise under the following circumstances:

(a) If you declined coverage for yourself or your eligible dependents under any of these health benefit programs when first eligible because you or they were enrolled in other health coverage, but have since lost that coverage on account of:

- exhaustion of COBRA continuation coverage,
- losing eligibility for the other coverage, or
- termination of Company contributions towards the other coverage,
you and your eligible dependents may enroll in these benefit programs on or before the **30th day** after you exhausted or terminated the other coverage. Your participation in these benefit programs will begin no later than the first day of the month after your timely enrollment request.

(b) If you initially declined enrollment in the applicable health plan benefit programs for yourself or your eligible dependents and you later have a newly eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your eligible dependents, provided that you request enrollment during the **30-day period** following the date of the marriage, birth, adoption or placement for adoption. Election changes related to a birth, adoption or placement for adoption will take effect as of the date of the birth, adoption or placement for adoption. Election changes related to your marriage will take effect no later than the first day of the month after your timely enrollment request.

(c) You or your dependent(s) will be permitted to enroll in coverage in either of the following circumstances.

- You or your dependent’s Medicaid or state Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility. You must request to enroll in our group health plan within 60 days from the date you or your dependent loses coverage.

- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or the state Children’s Health Insurance Program (CHIP). You must request to enroll in our group health plan within 60 days from the date you or your dependent becomes eligible for a premium assistance subsidy.

It is your responsibility to notify the Plan Administrator within **60 days** of either of these events. For further details on Medicaid or the state CHIP, contact your state’s Insurance Commissioner for the appropriate state agency or you can obtain, without charge, a copy of the CHIRPA notice from the Plan Administrator.

**Failure to Timely Enroll**

If you do not deliver a completed enrollment form to the Plan Administrator during your Initial Enrollment Period, a Special Enrollment Period, or an Annual Enrollment Period, you generally will not be covered under the programs, unless the component benefit programs provides for automatic enrollment or the Plan Administrator decides to implement a default election procedure or is otherwise required by law to do so. The Plan Administrator will notify you in writing (e.g. in the initial or open enrollment materials) of any such default election procedures, including a description of the default elections, the amount of the salary reduction, the period of time for which the election is effective, the procedures to decline coverage and the deadline for making elections.

**Procedures for Changing Elections Mid-Year**

Under certain circumstances, you may change your benefit program elections outside of the Annual Enrollment Period, subject to the terms of the component benefit programs, including the terms of any cafeteria plan maintained by the Company under Code Section 125. All changes to your benefit program elections must be submitted to the Plan Administrator using the enrollment form made available or required by the Company by the communicated due date.

**Participation During a Leave of Absence**

For any leave, paid or unpaid, for which you are eligible under the FMLA, you will remain a participant in the Plan, and will be entitled to receive the health program benefits you were receiving immediately before the start of your FMLA leave. The Company also intends to allow you to continue to receive all other Plan benefits during your FMLA qualified leave, to the extent possible and permitted by the terms of the component benefit program.
With respect to a leave that is not eligible under the FMLA, coverage will be continued only to the extent the leave is classified as a Company-Approved Leave of Absence and such continued coverage is specifically permitted under the terms of the benefit program booklets. Except as otherwise provided in an applicable benefit program booklet, Company-Approved Leave shall mean any leave of absence during which you are receiving benefits under the Company’s Short Term Disability Plan, or any other leave of absence that the Company has approved in writing and has specifically agreed in writing to continue your coverage under a particular component benefit program during such leave period. Except as otherwise provided in the benefit program booklet, “Company-Approved Leave” will not include any period of time during which the eligible employee is entitled to receive long-term disability benefits under the Company’s long-term disability plan or any period after the eligible employee fails to return to work following the expiration of his or her Company-Approved Leave.

With respect to all leaves:

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Company before the start of your leave.

- If you wish to continue your participation in the Plan, and you are currently required to contribute a certain amount for your coverage, you must make arrangements with the Company to pay for the coverage you wish to maintain during the course of your leave. If your leave is a paid leave, you automatically will continue having your compensation reduced as it was before your leave. If your leave is unpaid, you generally can pay your benefit contributions, subject to the terms of the Company’s Cafeteria Plan, under one of the following methods:
  - in advance of your leave; or
  - during your leave by sending a check monthly to the Company.

- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not timely make the required payments during the period of your leave, unless you have made other arrangements with the Company. The Company will send you advance notice of any cancellation.

- If the Company advances money by making these payments for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave.

- When you return from your FMLA leave, you are not required to re-satisfy the waiting period under the benefit programs.

- If you fail to return to work with the Company after your Leave period is exhausted, you will be indebted to the Company and the Company retains the discretion to recover from you the full amount of the cost of health care coverage provided to you and your dependents under the Plan during such Leave period.

Again, consult with the Plan Administrator before taking any leave of absence in order to determine whether and for how long your coverage under the Plan’s benefit programs will continue during the leave of absence.

**End of Plan Participation**

You and/or your Eligible Dependents’ coverage under the Plans generally will terminate under the circumstances and on the dates described in this section. However, you may have the opportunity to temporarily continue health coverage under circumstances described in Appendix B, or as described below regarding continuation of coverage during periods of absence, during military leave of absence and COBRA continuation coverage.
**Termination of Employment.** If your employment terminates, voluntarily or involuntarily, or you otherwise stop active work, then your coverage and your covered Eligible Dependents’ coverage under the Plan generally will terminate at 11:59 p.m. on the date your termination occurs, except as otherwise specifically provided in this document, in a written employment policy, severance, layoff or other agreement, or in Appendix B.

**Job Classification Change.** If you are transferred to a job position that is ineligible for health and welfare benefits under the Plan or you otherwise cease to be an eligible employee, then your coverage and your eligible dependents’ coverage under the Plan generally will terminate at 11:59 p.m. on the date your job transfer occurs, except as otherwise specifically provided in this SPD document, in a written severance, layoff or other agreement, or in Appendix B.

**Failure to Pay Required Contributions.** If you and/or any covered eligible dependent fail to timely make any required contributions to the Plan, your coverage and your eligible dependents’ coverage will be terminated on the date established by the Plan Administrator.

**Dependents.** Your eligible dependents’ coverage under the Plan will terminate on the earliest of:

- the date your coverage terminates for any reason; or
- at 11:59 p.m. on the date your Eligible Dependent ceases to meet any of the dependent eligibility requirements, as specified in this document, Appendix B or the component benefit program (e.g. on the date a decree, judgment or order of divorce, separate maintenance or legal separation is issued between you and your Spouse, or the date your dependent-child no longer meets the eligibility criteria).

You must notify the Plan Administrator within 30 days of the date a covered Spouse no longer is eligible to participate in the Plan as a result of divorce, legal separation or decree of separate maintenance, or death. You also must notify the Plan Administrator within 30 days of the date a dependent child no longer is eligible to participate in the Plan as a result of any qualifying factor specified under this Plan or the component benefit program. Please carefully review the COBRA coverage provisions below regarding your responsibility to timely notify the Plan when a dependent is no longer eligible; failure to do so will result in a loss of COBRA continuation coverage rights.

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

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

**Other Termination.** Your coverage and your Eligible Dependents’ coverage under the Plan will terminate on the date of termination of the Plan or termination of the part of the Plan providing benefits to you or your eligible dependents. Your coverage and your Eligible Dependents’ coverage under the Plan also will terminate as of any other date specified in the component benefit program documents or Appendix B.
Notwithstanding anything to the contrary, your employment or active work status will end as of the date you fail to return to work with the Company after your FMLA leave, USERRA leave or Company-Approved Leave has ended, or as of the date you begin receiving long-term disability benefits under the Company’s long-term disability plan (except as otherwise provided under Company policies).

**COBRA CONTINUATION COVERAGE**

This section generally explains COBRA Continuation Coverage, where it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation coverage may be administered by a third party administrator identified in Appendix A or the benefit program booklet.

COBRA continuation coverage is a continuation of group health plan coverage when that coverage would otherwise end because of certain “qualifying events.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose group health coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**Qualifying Events**

**For covered employees** – If you are a covered employee in the Plan, you may be entitled to elect continuation coverage if you lose your group health coverage because of:

- a termination of your employment (for reasons other than gross misconduct);
- a reduction in your hours worked (including any decrease in the number of hours worked or are required to work, including leave of absence, disability or layoff); or
- failure to return to employment following an FMLA leave (a “qualifying event”).

**For covered spouses** – If you are the spouse of a covered employee and are covered under the Plan, you may be entitled to elect continuation coverage if you lose group health coverage for any of the following reasons:

- A termination of your spouse’s employment (for reasons other than gross misconduct), a reduction in your spouse’s hours of employment; or your spouse’s failure to return to employment following an FMLA leave;
- The death of your spouse;
- Divorce or legal separation from your spouse;
- Your spouse becomes entitled to Medicare (Part A or B).

**Special Circumstance for Divorce** – If a covered spouse loses coverage in anticipation of a divorce, COBRA rights may still be available. For example, if the employee drops coverage on the spouse prior to the date the divorce is finalized (e.g. during the Annual Enrollment Period), the spouse may be entitled to COBRA continuation coverage if the Plan Administrator is notified within 60 days of the divorce. **It is the spouse’s responsibility to inform the Plan Administrator of the date of divorce.** If COBRA is elected and paid, the coverage will be reinstated effective the date of the divorce.

**For covered dependent children** – If you are the dependent child of a covered employee and are covered under the Plan, you may be entitled to elect continuation coverage if you lose group health coverage for any of the following reasons:
• A termination of the employee’s employment (for reasons other than gross misconduct), or a reduction in the employee’s hours of employment
• The death of the employee
• Parents’ divorce or legal separation
• The employee becomes entitled to Medicare (Part A or B)
• You cease to be a “dependent child” under the Plan

If a covered employee elects COBRA continuation coverage and a child is born to or placed for adoption with the covered employee during the continuation coverage period, COBRA coverage may be elected for the child as well. The child’s coverage period will be determined according to the date of the qualifying event that gave rise to the covered employee’s COBRA coverage, providing the plan is notified within 30 days of the birth or placement for adoption.

Notification Requirements for Covered Employees, Spouses, and Dependents

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, failure to return to work following an FMLA leave, death of the employee, or enrollment of the employee in Medicare (Parts A, B, or both), the Company must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

You and/or your covered spouse or dependent-child (or any representative acting on your behalf) must inform the Plan Administrator (or the COBRA Administrator identified in Appendix A) of the occurrence of each of the following events within the time described below:

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

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

• A determination that an individual (i.e. you or your covered Spouse or Dependent child) is disabled within the meaning of Title II or XVI of the Social Security Act at any time prior to or during the first 60 days of COBRA continuation coverage; such notice must be given within 60 days after the latest of (i) the date of a disability determination by the Social Security Administration, (ii) the date that the qualifying event occurs or (iii) the date on which coverage would be lost under the Plan because of the qualifying event; provided, however, that the notice must be given before the end of the first 18 months of COBRA coverage under all circumstances;

• The Social Security Administration’s determination that an individual is no longer disabled; such notice must be given within 30 days of the date of such determination; and

• Eligibility as a PBGC or TAA eligible individual (as described in paragraph (i) below); such notice must be given before the end of the first 18 months of COBRA coverage.

Any Notice under this paragraph must be sent in writing by U.S. mail to the COBRA Administrator and must contain the following information:
• the name of the covered employee and his or her social security number;
• the names of any covered Spouse and/or covered Dependent children;
• the identity of the Company-sponsored group health plans in which the covered individual(s) participate (e.g. Medical, Dental, Vision, and/or Health Care Spending Account Programs);
• a description of the event that triggers these notice requirements (e.g. the occurrence of a divorce, a child losing dependent status, a disability determination, a second qualifying event (including a description of the second qualifying event)); and
• the date on which such event occurred.

The Plan Administrator may require that the notice be supplemented with any additional information as it deems necessary to administer these COBRA provisions. Failure to timely provide written notice to the Plan Administrator under this paragraph will cause you (or your covered Spouse or Dependent child) to lose the right to receive or extend the period of COBRA coverage.

Election Period

Once the Plan Administrator is notified that a qualifying event has occurred, you and your covered dependents will be notified about your/their right to elect continuation coverage, or, if it is determined that you or your covered dependents do not qualify for such coverage, you or they will be notified as to why COBRA continuation coverage was denied. Each qualified beneficiary has an independent election right and will have 60 days from the later of the date coverage is lost under the Plan or from the date of notification to elect continuation coverage. A third party may make an election on behalf of a qualified beneficiary. This is the maximum election period; the Plan does not allow an extension beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this period, all rights to elect continuation coverage will end. In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health plan coverage could affect your future rights under federal law. First, you could lose the right to avoid having a pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you. (Please review the Health Care Reform Act provisions set forth below which limit how a plan may impose pre-existing condition exclusions). Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you otherwise are eligible (such as a plan sponsored by your Spouse’s Company) within 30 days after your group health coverage ends because of the qualifying event listed above. You also will have the same special enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you.

If a qualified beneficiary elects to continue coverage and pays the applicable premium, then each qualified beneficiary will be provided with coverage that is identical to the coverage provided under the Plan to other participants or beneficiaries who are not receiving COBRA continuation coverage. This includes offering the opportunity to make changes at annual enrollment and special enrollments. If coverage is changed or modified for participants or beneficiaries not receiving COBRA, then continuation coverage may be similarly changed and/or modified for any qualified beneficiary covered under COBRA.

If a covered employee or spouse of a covered employee elects COBRA without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event.

Length of Coverage
18-month period – If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct), a reduction in employment hours or failure to return to work following an FMLA leave, then each qualified beneficiary will have the opportunity to continue coverage for an 18-month period starting with the date of the qualifying event (or date of loss of coverage, if later). However, a termination of employment that follows a reduction in hours that has already resulted in your loss of coverage is not a qualifying event that creates another right to continuation coverage.

Disability extension. The 18 months of continuation coverage may be extended to 29 months if the Social Security Administration determines that, according to Title II or XVI of the Social Security Act, a qualified beneficiary was disabled prior to or during the first 60 days of continuation coverage, or in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, during the first 60 days after a child’s birth or placement for adoption.

All qualified beneficiaries with respect to the same qualifying event as the disabled qualified beneficiary are entitled to the extension. It is the qualified beneficiary’s responsibility to obtain this disability determination from the Social Security Administration, and the responsibility of any of the related qualified beneficiaries to provide a copy of the determination letter to the Company within 60 days of the date of determination and before the original 18 months of continuation coverage ceases. You must send notice to the Plan Administrator and to its COBRA Administrator identified in Appendix A.

If there is a final determination that the qualified beneficiary is no longer disabled, the Company must be notified within 30 days of the determination by the qualified beneficiary, and any coverage extended beyond the original 18 month maximum benefit period that would otherwise have applied will be terminated for all qualified beneficiaries. Notification must be made to the Plan Administrator and its COBRA Administrator identified in Appendix A.

Secondary events. Another extension of the 18-month period can occur, if during the original 18 months of continuation coverage, a second qualifying event occurs (divorce, legal separation, death, entitlement to Medicare, or loss of status as a dependent child). If a second qualifying event occurs, then the 18 months of continuation coverage may be extended to 36 months from the date of the original qualifying event. If you become entitled to Medicare and within 18 months thereafter lose coverage due to a termination of employment, reduction in hours or failure to return to work after the end of an FMLA Leave period, your Spouse and/or dependent children will be entitled to continuation coverage for a total of 36 months from the date you become entitled to Medicare.

If a second event occurs, it is the qualified beneficiary’s obligation to notify the Plan Administrator and its COBRA Administrator of the event within 60 days of the event and within the original 18-month period, in accordance with the notice procedures set forth above. In no event will continuation coverage last beyond 36 months from the date of the original qualifying event (or loss of coverage if later).

PBGC or TAA Eligible Individuals. If, as of the qualifying event date of termination of employment, you have a nonforfeitable right to receive any pension benefits directly from the Pension Benefit Guaranty Corporation, your maximum COBRA coverage period will be extended until the earlier of your date of death or January 1, 2014 (or such later date as extended by law). The maximum COBRA coverage period for your covered surviving Eligible dependent will be extended until the earlier of 24 months after your date of death, or January 1, 2014 (or such later date as extended by law).

• If you are an eligible individual under the Trade Adjustment Assistance Program as of the date your COBRA coverage would otherwise end (see below), your maximum COBRA coverage
period will be extended until the earlier of the date you cease to be an eligible individual under the Trade Adjustment Program, or January 1, 2014 (or such later date as extended by law). You must notify the Plan Administrator and COBRA Administrator in writing that you qualify as a PBGC or TAA eligible individual prior to the expiration of your initial 18-month COBRA period in accordance with the notice requirements set forth above.

**36-month period** – If the original qualifying event causing the loss of group health coverage was the death of the employee, divorce, legal separation, Medicare entitlement of the employee, or loss of “dependent status” of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event.

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

**Special Rule for the Health Care FSA Program**

The continuation coverage you may elect with respect to the Health Care FSA program, if any, is different from the continuation coverage you may elect with respect to the Medical, Dental and Vision programs offered by the Company.

First, continuation coverage for the Health Care FSA program is only available until the end of the plan year in which the qualifying event occurs and not for 18 or 36 months as for standard continuation coverage. It must be pointed out, however, that to receive continuation coverage, you must pay the applicable premium, and the Company is entitled to 2% administration charge. As the benefits under the Health Care FSA program involve reducing your compensation, and paying eligible health care expenses on a pre-tax basis, there are circumstances when you may be eligible for continuation coverage, but you will not be receiving any compensation that can be reduced under the Health Care FSA program. In such an event, you may end up having to pay 102% premium on an after-tax basis for only 100% coverage. Thus, even though continuation coverage is available, you must decide if it is a justifiable option for you based on its cost to you.

Second, the Company does not have to offer you continuation coverage if, at the time of the Qualifying Event, the premium you must pay for this coverage exceeds the maximum coverage remaining available to you for the plan year under the Health Care FSA program. For example, your plan year runs January through December and your annual election to the Health Care FSA program is $1,800. If you terminate employment in late March and you have already submitted claims totaling $1,000, then your remaining coverage would be $800, but your cost to keep this coverage would be $1,377 ($1,800 x 102% = $1,836/12 = $153/month x the 9 months remaining in the plan year). In this case, you would not be entitled to continuation coverage under the Health Care FSA program. Before electing continuation coverage under the Health Care FSA program, you should contact the Plan Administrator and evaluate your alternatives.

**Eligibility, Premiums and Conversion Rights**

You do not have to show that you are insurable to elect continuation coverage. However, you must be covered under the Plan at the time of a qualifying event in order to be eligible to elect continuation coverage (except for children born to or placed for adoption with a covered employee during the continuation coverage period). The Company reserves the right to verify eligibility and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary may have to pay the entire applicable premium plus a 2% administration charge for continuation coverage. These premiums may be adjusted in the future if the applicable premium amount changes. In addition, if the continuation period is extended beyond 18 months due to a Social
Security Administration determination of disability, the Company may charge up to 150% of the applicable premium during the extended period for the disabled qualified beneficiary and any non-disabled qualified beneficiaries in the disabled beneficiary’s coverage group.

There is a grace period of (30) days for the regularly scheduled monthly premiums. **This is the maximum grace period under the plan; the plan does not provide for an extension beyond what is required by law.**

If a qualified beneficiary’s COBRA continuation coverage ends as a result of the expiration of the maximum coverage period, a qualified beneficiary may have the option to enroll in an individual conversion health plan provided under a fully-insured option during the 180 day period that ends on that expiration date, if a conversion plan is available. Review the benefit program booklet for more information regarding conversion rights.

**Termination of Continuation Coverage**

The law allows continuation coverage that has been elected and paid for to be terminated prior to the end of the applicable maximum continuation period for any of the following reasons:

- The Company ceases to provide group health coverage to any of its employees.
- Any required premium is not paid in a timely fashion.
- A qualified beneficiary becomes covered, after the date on which COBRA was elected, under another group health plan, including a governmental plan, which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.
- A qualified beneficiary becomes entitled to Medicare on a date after the date of the COBRA election.
- A qualified beneficiary who has extended coverage due to a disability is determined by the Social Security Administration to be no longer disabled.
- A qualified beneficiary notifies the Company that he/she wishes to cancel continuation coverage.
- For cause, such as fraudulent claim submission, on the same basis that coverage could terminate for active plan participants or beneficiaries not receiving COBRA.

**Address Changes**

In order to protect your family’s rights under COBRA, it is important that you keep the Plan Administrator informed of any changes in the addresses of family members. Failure on your part to do so may result in delayed notification and loss of continuation coverage options.

**TAA-Related Loss of Coverage**

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance (TAA eligible individuals). Under the current version of this tax provision, TAA eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you are a TAA eligible individual and you did not elect COBRA continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, you may elect COBRA continuation coverage during a 60-day period that begins on the first day of the month in which you are determined to be a TAA-eligible individual (the “TAA election period”); provided, however, that your election is made not later than 6 months after the date of the TAA-related loss of coverage. You may elect COBRA coverage for both yourself and your family members. Any COBRA coverage elected during this TAA election period will begin on the first day of the TAA election period, and not on the date on which coverage originally ended. However, the time between the original TAA-related loss of
coverage and the start of the TAA election period (i) will be counted toward the maximum COBRA duration period, but (ii) will not be counted for purposes of determining whether you had a 63-day break in coverage under ERISA Section 701(c)(2). If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at www.doleta.gov/tradeact/2002act_index.asp.

Questions?
If you do not understand any part of this COBRA Continuation Coverage section, please feel free to ask questions regarding the information or your obligations. It is very important to understand your COBRA rights in case you ever experience a loss of coverage. Please contact the Plan Administrator or the COBRA Administrator identified in Appendix A with your questions.

MILITARY LEAVE CONTINUATION COVERAGE
If you are called to active duty in the United States Armed Forces (including Coast Guard), The National Guard or the Public Health Service, you and your eligible dependents will be offered up to 24 months of continuation coverage under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA). If your leave is less than 31 days, you will have to make the same contributions towards your coverage as do active employees, but you cannot be required to contribute more than that amount. If your leave is longer than 31 days, then 102% of your share of the premium may be charged for the coverage. The maximum period for continuation coverage under USERRA is the lesser of:

- 24 months from the date your leave commences; or
- the period from the date your leave begins to the day after you fail to return to employment within the time allowed following discharge (for leaves less than 31 days, 1 day is allowed; for leaves 31–180 days, 14 days is allowed; for leaves longer than 180 days, 90 days is allowed).

The continuation coverage mandated under USERRA is alternate coverage to that provided under COBRA, and so the two coverage periods run concurrently, not consecutively. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate coverage under this continuation coverage. The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is not able to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the Company for representation. You also may bypass the VETS process and file a claim under the Plan’s internal claims procedures or bring a civil action for violations of USERRA.

HEALTH CARE REFORM ACT OF 2010
The Patient Protection and Affordable Care Act of 2010 (“PPACA”) was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (the “Reconciliation Act”) was enacted on March 30, 2010, (collectively referred to as the “Health Care Reform Act”). The provisions below describe the market reform provisions that may apply to the Plan, but these provisions are subject to and hereby incorporate by reference any additional guidance issued by the IRS, DOL or Health and Human
Services agencies. Notwithstanding anything in this document or the benefit program booklets to the contrary, if the Company maintains a separate policy or arrangement providing benefits, substantially all of which are for the treatment of the mouth (including any organ or structure within the mouth) or for the treatment of the eye, or such coverage is not an integral part of the major medical benefit coverage offered by the Company, then such separate dental and/or vision coverage will be exempt from complying with the market reform provisions of the Health Care Reform Act described in this Section (unless the benefits program booklet for such dental and/or vision benefit coverage elects to provide otherwise). Dental and/or vision coverage are not considered to be integral parts of a major medical benefit coverage (whether they are offered through the same plan or a separate plan) if (i) the participant has the separate right to elect not to receive dental and/or vision coverage and, (ii) he/she pays an additional premium or contribution for any elected dental and/or vision coverage.

Continued Eligibility for Children Until Age 26.

Notwithstanding anything to the contrary in the benefit program booklet, the Plan shall comply with the provisions of the Health Care Reform Act regarding the continued eligibility of children until age 26. Under the Health Care Reform Act, if the Plan permits an eligible employee to enroll his/her child for coverage under the Plan, the child must be permitted to continue such coverage until attainment of 26 years of age. The Plan shall not condition a child’s eligibility for dependent coverage on the basis of marital status, financial dependency, residency with the eligible employee, student status, employment status, eligibility for other coverage (except as provided below), and shall not vary the terms of the Plan based on the age of a child. However, the Plan, as set forth in the benefit program guide, may define the necessary relationship between the eligible employee and the child for such child to be eligible for coverage under the Plan (e.g. the Plan may require the Child to be the natural child, adopted child, child placed for adoption, legal guardian, etc (but the Plan may no longer require the child to be unmarried). The Plan, as set forth in the benefit program booklet, also may require financial dependency and other conditions on children over the age of 26 (e.g. with respect to a disabled child, the Plan may still require such child to be financially dependent on the employee). Except as otherwise provided in the benefit program booklet, the spouse of an enrolled child under the Plan or the child of an enrolled Child under the Plan is not eligible for coverage under the Plan.

With respect to a child whose coverage ended under the Plan or who was denied coverage (or was not eligible for coverage) under the previous terms of the Plan, all eligible employees were given, via written notice, a one-time, 30-day special enrollment period to enroll such child with coverage becoming effective as of the first day of the Plan Year beginning after September 23, 2010. If an eligible employee failed to enroll the child during this special period, he/she may have the opportunity to enroll the child during the Plan’s subsequent open enrollment or other special enrollment periods explained above. The Plan requires that an eligible employee’s child be enrolled in the same benefit package options as elected by the eligible employee and that such child continues to satisfy the eligibility and enrollment conditions as set forth herein and the benefit program booklet.

Lifetime and Annual Limitations

Except as otherwise permitted by law and this paragraph, the lifetime and/or annual limits on the dollar amount of benefits for any covered individual under the Plan no longer apply. If your coverage (or your eligible dependent’s coverage) ended by reason of reaching a lifetime limit under the Plan, the Plan afforded you during 2010 enrollment period, through a written notice, a 30-day special enrollment period for you to enroll for coverage effective as of the first day of the Plan Year beginning on or after September 23, 2010. Notwithstanding these restrictions:

- The Plan may impose annual or lifetime dollar limits, with respect to any covered individual, on specific covered benefits that are not essential health benefits, to the extent that such limits are otherwise permitted under applicable law.
• The Plan may exclude entirely all benefits for a certain condition (except as otherwise required by applicable law) (i.e. exclude benefits for a certain type of condition or treatment, but if any benefits are provided for such a condition or treatment, then the Plan must comply with the prohibition on such lifetime and annual limits).

• For Plan Years beginning prior to January 1, 2014, the Plan may establish, for any covered individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the amounts in the following schedule:
  ■ For a Plan Year beginning on or after September 23, 2010 but before September 23, 2011, $750,000;
  ■ For a Plan Year beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000; and
  ■ For a Plan Year beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

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

Limitations on Coverage Rescission

Your group health coverage under the Plan may not be rescinded, unless you or your eligible dependent performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Plan must provide at least 30 days advance written notice to you and any eligible dependent who would be affected before coverage may be rescinded.

For these purposes, a rescission of coverage means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission protected by this provision if (i) the cancellation is applied prospectively; or (ii) it is applied retroactively, but results from your failure to timely pay premiums or contributions towards the cost of coverage.

Prohibition on Pre-Existing Condition Exclusions

The Plan may not impose pre-existing condition exclusions on you or your Eligible dependents. The prohibition on pre-existing condition exclusions becomes effective (i) with respect to Eligible dependent Children who are under 19 years of age, on the first day of the Plan Year beginning on or after September 23, 2010; and (ii) with respect to all other covered individuals, on the first day of the Plan Year beginning on or after January 1, 2014.

Waiting Periods

Effective for Plan Years beginning on and after January 1, 2014, the Plan shall not impose a waiting period in excess of 90 days.

Preventive Services

A group health benefit option must provide coverage for all “recommended preventive services” and may not impose any cost-sharing requirements (e.g. deductibles, coinsurance or copayments) to eligible
employees and eligible dependents with respect to such preventive services. The term “recommended preventive services” shall have the meaning ascribed to it under the Health Care Reform Act’s related regulations which are incorporated by reference.

A list of items or services that are considered recommended preventive services can be found at http://www.HealthCare.gov/center/regulations/preventive.html. Any new recommended preventive service also will be noted on this site; non-grandfathered group health benefit options under the Plan must modify its terms to include coverage with no cost-sharing requirements for any newly recommended preventive services as of the first Plan Year beginning on or after the date that is one year after the new recommendation went into effect.

The Plan is not required to provide coverage and/or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service, or if such item or service is delivered out-of-network.

If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, the Plan may impose cost-sharing on the office visit. If the recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a recommended preventive service, the Plan may not impose cost-sharing requirements with respect to the office visit. However, if the recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a recommended preventive service, the Plan may impose cost-sharing requirements with respect to the office visit.

**Patient Protections**

The Plan shall comply with the patient protection provisions of the Health Care Reform Act, as follows:

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

- If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrical or gynecology health care professionals, please contact the Plan Administrator or the insurer identified in the Appendix A.

- To the extent such a group health option provides any benefits with respect to services in an emergency department of a hospital, such option must provide emergency services (i) without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis; (ii) without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; (iii) if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage this is more restrictive than the requirements or limitations that apply to emergency services from in-network providers; (iv) if the emergency services are provided out-of-network, without imposing cost-sharing requirements of copayments and/or coinsurance that exceed those that apply to emergency services provided by an in-network provider (other than as permitted under the Health Care Reform Act’s related regulations); and (v) without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted by law, or applicable cost
sharing. Any cost-sharing requirement, other than copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum), may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

Prohibition on Discrimination in Favor of Highly Compensated Individuals with respect to a Fully-Insured Group Health Benefit Option

With respect solely to a fully-insured benefit option under the Plan for a Plan Year beginning on or after the effective date established under regulations of the IRS/DOL/HHS, such fully-insured option must satisfy the requirements of Code Section 105(h)(2) which prohibit discrimination in favor of highly compensated individuals as to eligibility to participate in and benefits offered under such option. The Company could be subject to excises taxes under Code Section 4980D if such fully-insured option under the Medical Plan fails to satisfy these non-discrimination requirements.

New Appeal and External Review Claims Procedures

In addition to the claims procedures set forth in the benefit program booklets and below, and effective on the dates established under regulations and other guidance provided by IRS/DOL/HHS, such Plan option must comply with the Consumer Appeal Rights under the Health Care Reform Act, including the following requirements:

1. A claimant shall have the right to the Plan’s internal claims and appeal processes for any cancellation or discontinuance of coverage that has retroactive effect.

2. The Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator notifies the claimant of its decision to give the claimant a reasonable opportunity to respond to the Plan prior to that date. Before the Plan can deny a claim based on new or additional rationale, it must provide the claimant, free of charge, a notice of such rationale, which must be sent as soon as possible and sufficiently in advance of the date on which the Claims Administrator notifies the claimant of its decision to provide the claimant a reasonable opportunity to respond prior to that date.

3. The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved with making the claims decisions. Accordingly, the Claims Administrator’s decision regarding hiring, compensation, termination, promotion or other similar matters with respect to any claims adjudicator or medical expert, must not be made based upon the likelihood that the individual will support a denial of benefits, contract with a medical expert based on the expert’s reputation for outcomes in contested cases other than based on the expert’s profession qualifications.

4. Any notice of an adverse benefit determination (i.e. denied claim) must be provided in a culturally and linguistically appropriate manner, as defined in the Health Care Reform Act’s related regulations (published at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.136)), which may require notices to be provided in non-English language.

5. Any notice of an adverse benefit determination must include the following information:

   • date of service;
   • the health care provider; the claim amount (if applicable);
   • a description of how to request the diagnosis and treatment codes with the corresponding meaning of such codes;
• the reason(s) for denial must include the denial code and its corresponding meaning;
• a description of the Plan’s standard, if any, used in denying the claim;
• a summary of the Claim Administrator’s discussion regarding its final decision to deny the claim;
• a description of the available internal appeals and external review processes, including information regarding how to initiate such processes; and
• disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Health Care Reform Act to assist claimants with the internal claims and appeals and external review processes.

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

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

8. A Claimant shall have the right to file a request for an independent, external review of the Plan’s decision. The Claimant must make this request within 4 months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination. The Plan shall comply with either a State’s external review process or the Federal external review process. If a State’s external review process applies and is binding on a fully-insured group health option offered under this Plan, and, at a minimum, after December 31, 2011, such process includes the consumer protections in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010, then the issuer of such fully-insured group health benefit option shall be required to comply with that State’s external review process (and the Federal external review process will not apply). A description of the minimum consumer protections under the NAIC Uniform Model Act are set forth in the Health Care Reform Act’s related regulations published at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.136, and DOL Technical Release 2010-01, as amended by DOL Technical Release 2011-02. If a State’s external review process does not apply to a group health benefit option offered under the Plan (e.g. because the option is a self-funded option or the State’s external review does not meet the minimum consumer protections of the NAIC Uniform Model Act after December 31, 2011), then the Federal external review process will apply; provided, however, that claims for which external review has not been initiated before
September 20, 2011, such Federal external review shall only apply to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage. The Federal external review process is similar to the process set forth under the NAIC Uniform Model Act and is explained in detail under the Health Care Reform Act’s related regulations (published at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.136) and DOL Technical Release 2010-01. Generally, all adverse benefit determinations shall be subject to the external review process requirements, except for a decision relating to an individual’s failure to meet the requirements for eligibility under the terms of the Plan (e.g. worker classification and similar issues).

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN’S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call the medical claim administrator at the phone number on the back of your identification card.

MENTAL HEALTH PARITY ACT

The MHPA requires certain group health plans to provide equal treatment of mental health and substance use disorder benefits in parity with medical/surgical benefits. This generally means that:
• Financial requirements and treatment limits applicable to mental health and substance use disorder benefits be no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coins, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);

• Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance use disorder benefits; and

• Criteria for medical necessity and reason for claim denials must be made available.

The benefit program booklet for the component benefit programs that are subject to this law will provide an explanation of the covered and excluded benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits the Company and the Plan from:

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

• Adjusting your premium and contribution amounts on basis of genetic information;

• Requesting or requiring you or a family member to undergo a genetic testing;

• Requesting, requiring or purchasing genetic information for underwriting purposes; or

• Requesting, requiring or purchasing genetic information about an individual prior to or in connection with an individual’s enrollment under the plan

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

MICHELLE’S LAW

Michelle’s Law prohibits a group health plan from terminating coverage for a dependent student who takes a medically necessary leave of absence. Generally, coverage must continue for a dependent that otherwise would lose coverage under the group health plan for failing to maintain full-time enrollment status in a post-secondary institution because the dependent requires a medically necessary leave of absence. If you would like more information on Michelle’s Law, call the medical claim administrator.

PREEXISTING CONDITION EXCLUSIONS AND CERTIFICATES OF CREDITABLE COVERAGE

Please review the Health Care Reform Act provisions set forth above regarding the new rules prohibiting the Plan from imposing pre-existing conditions. Until these new rules under the Health Care Reform Act take full effect, this Section shall apply.

The benefit program booklet for a medical program will specify if you are subject to pre-existing condition exclusions. Any such preexisting condition exclusions must comply with HIPAA requirements.

A preexisting condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period
begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan or Claims Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan or Claims Administrator if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan or Claims Administrator to (with the assistance of the prior plan administrator or insurer) determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

The benefit program booklet describes any pre-existing condition exclusion in greater detail. Please review the benefit program booklet carefully (you can obtain another copy of it by contacting the Plan Administrator).

HIPAA also requires any medical program offered by the Company to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage by contacting the Plan Administrator or the Claims Administrator identified in Appendix A.

**HIPAA PRIVACY PROTECTIONS**

**Introduction**

This section only applies to a benefit program that is a group health plan (e.g. the medical, prescription drug, dental, vision, EAP and Health Care Flexible Spending Account programs).

The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing privacy and security regulations (collectively referred to as “HIPAA”) restrict the Company’s and Plan’s ability to use and disclose certain health information known as “protected health information” (“PHI”) and requires that certain security measures be implemented with respect to any electronic PHI.

To the extent subject to HIPAA privacy and security laws, the Plan and the Company intend to fully comply with HIPAA. However, the Plan and the Company also intend to comply with the requirements of 45 C.F.R. § 164.530(k) so that the Plan and the Company are not subject to most of HIPAA’s privacy requirements. The Plan, through the Company, has entered into insurance contracts and/or third party administrative and business associate agreements with Business Associates to perform all administrative functions on behalf of the Plan, including HIPAA compliance. As a result, the Authorized Employees of the Company generally will not receive, use, maintain, disclose or transmit PHI or ePHI on behalf of the Plan. The Company, in its capacity as the employer, typically will have access only to certain enrollment and disenrollment information regarding the Plan’s participants (including participant name, social
security number and election amount under the Plan) and to Summary Health Information. To the extent that the Company is subject to HIPAA and its Authorized Employees actually receive, use, maintain, disclose or transmit PHI or ePHI, then the Company will implement the administrative, technical and other safeguard policies and procedures required by HIPAA and as specified below.

Definition
Throughout this Article, various terms are used repeatedly. These terms have specific and definite meanings and generally have been capitalized throughout this Article. Whenever capitalized terms appear, they shall have the meanings specified in HIPAA. HIPAA generally defines PHI and electronic PHI as follows:

**PHI** includes information that (i) the Plan creates or receives, (ii) relates to the past, present, or future health or medical condition of an individual and, (iii) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. **Electronic PHI** is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc.).

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

- The Plan may share PHI with government or law enforcement agencies when required to do so or when required to in a court or other legal proceeding;
- The Plan may share PHI to obey Workers’ Compensation laws; and
- The Plan may share PHI with the individual if the individual requests access to PHI.

Hybrid Entity Election
The document is a wrap plan document that incorporates by reference separate Plan documents, some of which are group health plans and others are non-group health plans. As a result, HIPAA may treat this wrap plan document as offering a healthcare component and a non-healthcare component and consequently, it may be considered a “hybrid entity” as defined under Section 45 CFR 164.103 of HIPAA. In this case, the healthcare component of this document consists of the group health plans (e.g. the medical, prescription drug, dental, vision, EAP, health care flexible spending account programs). The non-healthcare component of the Plan consists of other (non-health care) Plans (e.g., disability and life insurance programs, and Cafeteria Plan). The Plan and Company intend to comply with HIPAA with respect to only the healthcare component of the Plan and to ensure adequate separation between the healthcare component and the non-healthcare component (i.e. such healthcare component and non-healthcare component are separate and distinct plans). In this regard and to the extent required by HIPAA, the Plan and the Company will ensure compliance with the safeguard requirements relating to hybrid entities as set forth in Section 45 CFR 164.105(a) of HIPAA and in the Plan’s HIPAA Privacy Policies and Procedures.
Company Certification

The Plan may disclose PHI to the Company (including certain members of the Company’s workforce) only to perform administrative functions on behalf of the Plan in a manner consistent with HIPAA requirements, and as more fully described in the Company’s HIPAA Privacy and Security Policies and Procedures. In this regard, the Company adopts and signs this wrap plan document as certification to the Plan that the Company will appropriately safeguard and limit the use and disclosure of PHI that it receives from the Plan only to perform plan administration functions. Specifically, the Company agrees to:

- use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA;
- ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Company with respect to such information;
- not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan;
- report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;
- make available information in accordance with the HIPAA Rules regarding individual access to PHI;
- make available PHI for amendment in accordance with the HIPAA Rules;
- make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;
- make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
- if feasible, return or destroy all PHI received from the Plan that Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- ensure adequate separation between the Plan and Company;
- to the extent required by HIPAA, ensure compliance with the safeguard and other requirements specified under 45 CFR 164.105(a) relating to hybrid entities and the healthcare component of the Plan; and
- to the extent it creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, the Company will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Company will report to the appointed Security Official any security incident of which it becomes aware, and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions of Section 10.7 are satisfied.
Workforce of the Plan

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

Certain employees of the Company whose duties include administrative and management functions on behalf of the Plan also are considered part of the Workforce of the Plan and thus privacy and security fiduciaries of the Plan. Their access to PHI is limited to the minimum necessary information needed to perform administrative functions on behalf of the Plan, including using or disclosing Summary Health Information for the purpose of obtaining premium bids (including bids in connection with the placement of stop loss coverage) or making decisions to modify, amend or terminate the Plan, or enrollment or disenrollment information about participants. The Company’s HIPAA Privacy and Security Policies and Procedures includes a complete listing of the designated employees who serve as members of the Workforce with access to PHI or electronic PHI.

Adequate Separation between the Plan and Company

The Company shall allow access to PHI received from the Plan only to those Workforce members who have been specifically designated by Company as individuals authorized to access PHI pursuant to the Company’s HIPAA Privacy and Security Policies and Procedures.

No other persons shall have access to PHI. These individuals who have authorized access to PHI only shall use and disclose PHI to the extent necessary to perform the plan administration functions that Company performs for the Plan. These authorized individuals generally may not use or disclose PHI for purposes of payment, operation or other administrative functions of the Company’s non-group health benefit plans (e.g. disability, life insurance, workers compensation, dependent day care spending account plans etc.) or of any other non-plan activity such as employment related decisions without individual authorization. The Company will ensure that the adequate separation between the Plan and Company is supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

Violations of Privacy or Security Rules

If Company becomes aware of violations of these HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or Security Officer appointed by Company to consult with the person who has violated the privacy or security rules with respect to his or her obligations under the privacy or security rules. A person who violates these privacy or security rules may be subject to discipline up to and including discharge. The Company also shall comply with any notice requirements regarding breach of Unsecured PHI, as set forth in the Company’s HIPAA Privacy and Security Policies and Procedures.

Individual Rights

The Plan will provide Participants with certain individual rights to access, amend, account for or restrict uses or disclosures of PHI, as more fully described in the Plan’s Notice of Privacy Practice and HIPAA. A copy can be obtained, without charge, from Human Resources.
COORDINATION OF BENEFITS

“Coordination of Benefits” is the procedure used to pay health care expenses when a person has coverage under this Plan as well as coverage under another plan, program, or policy providing health care benefits, including but not limited to an automobile insurance policy. The plan, program or policy that is deemed to be the “primary plan” must pay its full benefits as if no other coverage existed. The remaining plan, program or policy is deemed the “secondary plan” and is only required to pay its benefits that are in excess of those paid by the primary plan. The following rules shall govern the coordination of benefits, except as otherwise provided in the benefit program booklet:

• The plan that covers the patient as the employee is primary and pays before the plan that covers the patient as a dependent.

• The plan that covers the patient as an active member (e.g., employee) is primary and pays before the plan that covers the patient as an inactive member (e.g., retiree, COBRA continuee, etc.).

• If a child is covered under both the mother’s and father’s plan, the plan of the parent whose birthday is earlier in the year is primary.

• For children of divorced parents or separated Spouses, benefits are determined in the following order unless a Qualified Medical Child Support Order (as defined above) places financial responsibility on one parent:
  ■ The plan of the custodial parent.
  ■ The plan of the custodial parent’s new Spouse (if remarried).
  ■ The Plan of the non-custodial parent.
  ■ The plan of the non-custodial parent’s new Spouse.

If the primary plan cannot be determined for the children of divorced or separated parents under these rules, then the “birthday rule” under the third bullet above will be used to determine the primary plan.

• Except as otherwise required by state law that is not preempted by ERISA, if you or an Eligible Dependent are involved in a motor vehicle or cycle accident, payment for medical or other expenses will be coordinated between this Plan and your auto or motorcycle insurance carrier as follows:
  ■ Whether your auto or motorcycle coverage policy is coordinated or uncoordinated, your auto or motorcycle insurance policy/carrier is primary; and
  ■ This Plan will be secondary to your auto or motorcycle insurance.

The Plan generally will reject auto or motorcycle accident related claims received until you submit proof of primary payment by the auto or motorcycle insurance policy. If you fail to maintain the minimum statutorily required auto or motorcycle insurance policies, the Plan, at its discretion, may exclude coverage for all medical expenses incurred relating to an auto or motorcycle accident. It is important that you discuss the Plan’s treatment of your auto or motorcycle insurance coverage as the primary payer with your auto or motorcycle insurance carrier. Please note that state insurance law may state that no-fault auto insurance pays second, but such state law does not apply to any of the self-funded health benefit options offered under the Plan because ERISA preempts such state law from determining the coordination of benefits under such self-funded group health options.
EXAMPLE: Assume you have no-fault automobile or motorcycle insurance and are injured in an automobile or motorcycle accident. Your automobile or motorcycle insurer will be the primary party responsible to pay your medical related expenses and this Plan will pay only after such auto or motorcycle insurance coverage benefits have been exhausted.

- Any situations not addressed in the Plan will be handled in accordance with the guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

You must notify the Plan Administrator of any other health care plans in which you and/or your dependents participate.

To the extent required under the Medicare Secondary Payer Act (e.g. the Company has 20 or more employees), if you are age 65 and eligible for Medicare while still working for the Company, the Plan automatically will remain the primary plan and Medicare will be the secondary plan. However, you still should apply for Medicare benefits, especially Part A, because it may provide additional health care benefits to you, even as the secondary plan.

**SUBROGATION**

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered individual in a time of need, the Plan may pay covered expenses that may be or become the responsibility of another person, contingent on the individual’s agreement that the Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

- **Assignment of Rights (Subrogation).** The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

- **Equitable Lien and other Equitable Remedies.** The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers or the Company will be deemed to mean that such a determination has been made.

This equitable lien also shall attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person’s attorney, and/or a trust) as
a result of an exercise of the covered person’s rights of recovery (sometimes referred to as “proceeds”). The Plan also shall be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (1/8/2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies also are intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

Assisting in Plan’s Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan’s exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan’s subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan’s rights.

Overpayments. This Plan will have the right to recover any payments that were made to, or on behalf of, a covered individual and which causes an overpayment to be made.

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

Jurisdiction. By accepting benefits (whether the payment of such benefits is made to a covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

The benefit program booklet also may set forth subrogation rights and procedures. Failure by a covered person to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.
CONVERSION

Please refer to the benefit program booklet that applies to the component benefit program to determine if you are eligible to convert your group coverage to an individual insurance policy after your group coverage terminates. It is your sole responsibility to timely contact the component benefit program Insurer for information about the availability of this conversion coverage and the rules concerning your eligibility for conversion coverage when your group coverage ends under this Plan.

BENEFIT AUTHORIZATION PROCEDURES, PPO AND HMO INFORMATION, WELLNESS INITIATIVES AND PATIENT PROTECTIONS

Authorization Procedures

Certain benefits under the Plan may require prior authorization before those benefits will be covered under the Plan. The benefit program booklet lets you know when prior authorization is required. The benefit program booklet also describes the procedures for obtaining this prior authorization.

HMO/PPO Information

If the benefit program booklet specifies that a particular benefit program is offered through a Preferred Provider Organization (PPO) or Network system, this means that you are offered a choice to utilize either designated health care providers or non-designated health care providers. If you (and your covered eligible dependents) use designated health care providers, you generally will experience a higher level of benefits (i.e. at lower cost to you) than if you use non-designated providers. Benefit levels for in-network and out-of-network services are outlined in the benefit program booklet. A listing of designated health care providers is available at no charge through the Plan Administrator or through the insurance carrier for the applicable PPO (identified in the Appendix A or benefit program booklet that applies to your employee group).

If the benefit program booklet specifies that a particular benefit program is offered through a Health Maintenance Organization (HMO), this means that you (and your covered eligible dependents) must each select a Primary Care Physician (PCP) from the HMO network. Your PCP will be responsible for coordinating all of your health care through other providers and specialists within the HMO network. If you bypass your PCP or use providers outside of the HMO network, there generally will be no coverage (except in the case of emergency). If the Company decides to offer an HMO option, a listing of PCP and other HMO network providers will be made available at no charge through the Plan Administrator or through the carrier for the HMO. The Company will notify you during Open Enrollment if an HMO option becomes available.

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

Wellness Incentive Programs

The Company, at its sole discretion, may implement certain wellness initiatives to help Employees and their families achieve better health. The Company will furnish you with the benefit program booklet that will more fully describe such wellness initiatives, which may include activities such as weight management, smoking cessation, and other lifestyle behavior change initiatives. Participation in some of
these programs may make you eligible for a reward or incentive, which could help to pay for some of your health care expenses. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees who are employed by a location that sponsors a wellness program. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Patient Protections

Please review the Health Care Reform provisions above, which explain certain patient protection rights in selecting providers and emergency room services that may apply to benefit options under the Medical Plan.

CLAIMS FOR BENEFITS

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

However, the claim procedures that are described in the remaining sections of this section will apply in the event that (i) the claim relates to the administration of this Plan, (ii) a particular benefit program does not prescribe a claims procedure that satisfies ERISA requirements, or (iii) the Plan Administrator determines that the claims procedures specified below should apply in lieu of the claims procedures described in a particular component benefit program. Please also review the Health Care Reform Act provisions above, which sets forth special claims procedures and external review rights that apply to a group health benefit option.

Initial Claims

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

• The name and address of the claimant;
• The specific basis for the claim;
• A specific reference to the applicable Plan and pertinent plan provision upon which the claim is based; and
• Any additional material or information which the claimant desires to submit in justification of the claim.

Claim Administrator’s Initial Determination

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

Health Benefit Claims. If the claimant files a claim for health care benefits, the following shall apply:
Urgent Care. An urgent care claim is a claim in which a delayed determination (i) could seriously jeopardize the life or health of the affected individual or the ability of the individual to regain maximum function, or (ii) in the opinion of an informed physician, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan shall defer to the attending physician with respect to the decision as to whether a claim constitutes “urgent care” for purposes of this Section.

Approval or denial of an initial urgent care claim will be furnished to a claimant as soon as possible taking into account the medical urgency, but not later than 72 hours after receipt of the claim. Any denial will contain a description of the expedited review process. This notice may be given orally, in which case a written notice will be sent within 3 days of the oral notice.

If more information is needed from a claimant, the Claims Administrator will notify a claimant not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. A claimant then has at least 48 hours to provide the information. The Claims Administrator will notify a claimant of the decision not later than 48 hours after the earlier of (i) the receipt of the specified information, or (ii) the end of the period afforded a claimant to provide the additional information.

Concurrent Care. If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments and the Claims Administrator makes a decision to reduce or terminate such course of treatment (other than by plan amendment or plan termination) before the end of the period of time or number of treatments, then the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination of the benefit to allow him or her to appeal and obtain a decision on review before the benefit is reduced or terminated.

If the Claims Administrator receives a request by the claimant to extend beyond the approved period of time or approved number of treatments a course of treatment that qualifies as “urgent care”, the Claims Administrator will notify the claimant of its determination no later than 24 hours after receipt of the claim, provided the claim is made at least 24 hours before the course of treatment otherwise is scheduled to terminate.

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

Post-Service Claim. A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to a claimant within 30 calendar days after receipt of the claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to a claimant’s failure to provide the necessary information, the Claims Administrator will describe the required information. A claimant will have at least 45 calendar days from receipt of the notice to provide the information.
Disability Benefit Claims. Approval or denial of an initial disability claim will be sent to a claimant within **45 calendar days** after receipt of the claim, unless extensions are required. The 45-day period may be extended twice, up to 30 calendar days each, provided the extensions are due to matters beyond the control of the Plan. A claimant will be notified of the first extension before the expiration of the initial 45-day period. A claimant will be notified of the second extension before the expiration of the first 30-day extension period. This extension notice will explain: the circumstances requiring an extension; the date by which the Claims Administrator expects to make the benefit determination; the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on a claim; and the additional information needed to resolve those issues. A claimant will be afforded at least 45 days within which to provide any specified information.

All Other Claims. Approval or denial of any other type of claim (not involving health or disability benefits) will be sent to a claimant within **90 calendar days** after receipt of the claim, unless an extension is required. The 90-day period may be extended once up to 90 calendar days, provided the Claims Administrator determines that special circumstances require an extension of time for processing the claim. A claimant will be notified of the extension before the expiration of the initial 90-day period. The extension notice will explain the circumstances requiring an extension and the date by which the Claims Administrator expects to make the benefit determination.

Claimant’s Deadline for Filing an Appeal of a Denied Claim

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

- **180 days** following receipt of the Claims Administrator’s denial of a group health or disability claim for benefits; or
- **60 days** following receipt of the Claims Administrator’s denial of any other type of claim.

Appeal Procedures

On appeal, the following procedures will apply:

- During the review, a claimant may represent himself or herself or will have the right to appoint a representative, provided that the claimant is responsible for all of fees and expenses of such representative.
- A claimant will have reasonable access (free of charge and upon request) to copies of all documents, records and other information relevant to his or her claim for benefits.
- A claimant will be provided the opportunity to submit, and any review will take into account, all comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- The review of a denied claim involving a group health plan benefit or disability benefit will be conducted by an independent fiduciary who is neither the individual who made the adverse decision nor a subordinate of that individual. Such reviewer will not give deference to the original decision to deny the claim. If the denial of the claim was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted, nor a subordinate of an individual who was consulted, in connection with the original adverse decision.
In the case of an urgent care claim for health benefits, the claimant may request expedited review of the claim whereby the request may be made orally or in writing and all necessary information may be transmitted between the Plan and the claimant by telephone, facsimile or other similar expeditious method.

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

Claims Administrator’s Deadline for Deciding an Appeal

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

Health Benefit Claims:

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

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

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

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

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

the Claims Administrator generally will notify the claimant of the decision within a reasonable period of time, but not later than 60 calendar days after receipt of the claim for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 60 day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination of a claimant’s appeal;
In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, subsection (1) above shall not apply. The appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan’s receipt of a request for a review, unless the request for review is filed within 30 days preceding the date of such meeting. In such a case, a benefit determination shall be rendered no later than the third meeting of the committee or board following the Plan’s receipt of the request for review. If the Claims Administrator determines that such an extension of time is required due to special circumstances, the Claims Administrator will notify the claimant, in writing, of the extension prior to the commencement of the extension, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The Claims Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Notice of Claims Administrator’s Decision

The Claims Administrator’s notice of its decision to deny a claim will set forth:

- the specific reasons for the denial;
- references to specific Plan and provisions of the Plan upon which the denial is based;
- for a notice involving the Claims Administrator’s initial decision on a claim -- a description of any additional material or information necessary for the claimant to perfect his or her claim along with an explanation of why such material or information is necessary, and an explanation of claim review procedures under the plan and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under ERISA Section 502(a) following an adverse decision on review;
- the specific rule, guideline, or protocol, if any, that was relied on in making the adverse decision, or a statement that the rule, guideline, or protocol will be provided to the claimant free of charge;
- if the adverse decision is based on a medical necessity or an experimental treatment limit or exclusion, either an explanation of the scientific or clinical judgment for the determination that applies the Plan to the claimant’s medical circumstances or a statement that the explanation will be provided free of charge on request;
- the identity of any medical or vocational experts whose advice was obtained by the Claims Administrator in the process of deciding the claim, regardless of whether Claims Administrator relied upon such advice; and
- the following statement if the claim involves health care or disability benefits: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency.”

General Claim Provisions

Notwithstanding anything to the contrary, the following provisions will apply to all claims:

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

**Limitation of Claims Procedure.** Except as otherwise required under and subject to the terms of a Plan, including Sections 6.10 and 6.11, any claim under this claims procedure must be submitted **within 12 months** from the earlier of:

- the date on which the claimant learned of facts sufficient to enable him to formulate such claim, or
- the date on which the claimant reasonably should have been expected to learn of facts sufficient to enable him to formulate such claim.

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

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

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

**Forfeiture of Uncashed Checks.** If the Plan (through the Company, or its third party administrator or insurer) makes payment to you (and/or to your eligible dependents or to a provider on your behalf) of an approved benefit claim and the check for such benefit claim remains uncashed (regardless of the reason) for a period of more than one (1) year after the issue date of the check, then you (and/or your eligible dependents or the provider) will forfeit all rights for reimbursement or payment of such benefit claim under the terms of Plan and you will not be entitled to reinstate your rights with respect to such benefit claim at any time thereafter. Also, the Plan generally requires that you submit your initial claim for payment within 12 months after the date of service for benefit claims (or by the earlier deadline with respect to Spending Account Plans). If you submit your claim after the applicable deadline, then you (or your eligible dependents or the provider acting on your behalf) will forfeit all rights to payment or reimbursement under the Plan, and the Plan will deny such benefit claim.
ADDITIONAL INFORMATION ABOUT THE PLAN

Plan Year
The operation and records of the Plan are maintained on a January 1st through December 31st basis. (Please note that the policy/renewal year for the various benefits may not necessarily correspond with the Plan’s designated plan year.)

Plan Number
The Plan Sponsor has assigned the Plan Number 502 to the Plan.

Plan Sponsor, Plan Administrator, Named Fiduciary and Agent for Service of Legal Process
Asahi Kasei Plastics North America, Inc.
Attention: Human Resources Director
900 E. Van Riper
Fowlerville, MI 48836
517-223-2000

Plan Sponsor’s Employer Identification Number
38-1842563

Other Participating Employers
Subject to the consent of Asahi Kasei Plastics North America, Inc., its affiliates and subsidiaries may adopt the Plan. The section in Appendix A titled “Other Participating Employers” lists any affiliates and subsidiaries that have adopted the Plan.

Third Party or Claims Administrator
The Plan Administrator may allocate fiduciary, claim adjudication, COBRA and other responsibility to administer the component benefit programs to third party administrators or other claims administrators (e.g. to insurers). These delegated parties will be identified in the benefit program booklets or Appendix A.

Entire Representation
This document, along with any summary, schedule of benefits, booklets, separate insurance contract or certificate, service agreement, and enrollment materials are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).
Acceptance; Cooperation
If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents which may be necessary or desirable to carry out this Plan or any of its provisions.

Amendment or Termination of the Plan
The Company may amend, modify, or terminate this Plan at any time in any manner or with respect to any individual in its sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by the Code or ERISA. The Company has no obligation to continue the Plan or any benefit provided under the Plan, and a Participant’s right to a benefit always is forfeitable. Notwithstanding the foregoing, any such termination or amendment shall not adversely affect any Participant’s right under the Plan to benefits attributable to claims incurred prior to such termination or amendment.

Indemnification
The Company will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, loss, damages, expense and liability arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The Company may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense or liability arising from any employee’s action or failure to act.

Discretion / Nondiscrimination
Wherever it is provided in the Plan that the Plan Sponsor may perform or not perform any act, or permit or consent to any action, non-action or procedure, or wherever it shall be given discretionary power or authority, it shall have exclusive discretion in the premises; provided, however, that it shall not exercise its discretion in such a manner as to violate the Internal Revenue Code or ERISA or knowingly to discriminate either for or against any employee, retiree, participant or Covered Person or any group of such persons.

Errors
An error cannot give a benefit to you if you are not actually entitled to the benefit. If you receive any benefits in error or overpayments from the Plan, the Plan Administrator will have the right to recover such amounts from you at any time.

Limitation on Rights
The Plan does not constitute a contract between you and the Company, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of the Company or to interfere with the right of the Company to discharge you at any time, with or without cause, regardless of the effect which that discharge will have upon you as a participant in the Plan.
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.

Waiver

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

Governing Law

The Plan is to be construed and enforced in accordance with federal law and the laws of the State of Michigan, to the extent not preempted by federal law.

Non-Assignability of Rights

No right or interest under the Plan is subject to assignment or alienation, wherever voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Severability

The enforceability of any provision of the Plan shall not affect the enforceability of the remaining provisions of the Plan.

Return of Dividends, Premiums or Reserves

Because the amount of employee contributions is fixed each year and the Company makes up the difference between those contributions and the costs of the Plan, any dividends and returned premiums or reserves, credited under an insurance policy are the property of the Company. To that extent, dividends and return of premiums or reserves do not become assets of the Plan.

Tax Consequences

Neither the Company nor the Plan makes any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and you shall have no rights against the Company or the Plan if any tax consequences contemplated are not achieved.
Facility of Payment
If the Plan Administrator determines that you are incapable of receiving any disability benefits under the Plan that you are entitled to receive because you are ill, or otherwise incapacitated, the Plan Administrator may direct that payment be made on your behalf.

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

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

STATEMENT OF ERISA RIGHTS
As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

- Receive a summary of the Plan's annual financial report. The Plan Administrator may be required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA Continuation Coverage section for the rules governing your COBRA Continuation Coverage rights.

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive 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 Plan 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 Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
## APPENDIX A – BENEFIT PROGRAM INFORMATION

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<th>Benefit Program</th>
<th>Claims Administrator</th>
<th>Plan Funding</th>
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<tr>
<td><strong>Medical &amp; Prescription Drugs</strong></td>
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<td>- PPO 2 Plan</td>
<td>Please refer to the benefit program booklet for the address, phone number, and claim filing and appeal procedures.</td>
<td>Benefit contributions are required. You pay your benefit contributions on a pre-tax basis under the Pre-Tax Payment program.</td>
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<td>- PPO 3 Plan</td>
<td>P.O. Box 2888Detroit, MI 48231</td>
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<td>- Consumer Driven Health Plan</td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
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<td>877-790-2583</td>
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<td>P.O. Box 9085Farmington Hills, Michigan 48333-9085</td>
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<td><a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a></td>
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<td>800-524-0149</td>
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<td><a href="http://www.mutualofomaha.com">www.mutualofomaha.com</a></td>
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<td></td>
<td>800-877-5176</td>
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<tr>
<td>Life and Accidental Death &amp; Dismemberment (AD&amp;D) –</td>
<td>Mutual of Omaha</td>
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<tr>
<td>Basic Coverage</td>
<td>EIN: 47-0322111</td>
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<td>Please refer to the benefit program booklet for the</td>
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<td>address, phone number, and claim filing and</td>
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<td>appeal procedures.</td>
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<td>Mutual of Omaha Plaza</td>
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<td>Omaha, Nebraska 68175</td>
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<td><a href="http://www.mutualofomaha.com">www.mutualofomaha.com</a></td>
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<td>800-775-8805</td>
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<tr>
<td>Life - Optional Coverage</td>
<td>Mutual of Omaha</td>
<td>Insured</td>
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<td>800-775-8805</td>
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<td>Accidental Death &amp; Dismemberment - Optional Coverage</td>
<td>Mutual of Omaha</td>
<td>Insured</td>
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<td>appeal procedures.</td>
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<tr>
<td>Benefit Program</td>
<td>Claims Administrator</td>
<td>Plan Funding</td>
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<tr>
<td><strong>Benefit Program</strong></td>
<td><strong>Claims Administrator</strong></td>
<td><strong>Plan Funding</strong></td>
</tr>
<tr>
<td>address, phone number, and claim filing and appeal procedures.</td>
<td>Mutual of Omaha Plaza Omaha, Nebraska 68175 <a href="http://www.mutualofomaha.com">www.mutualofomaha.com</a> 800-524-2324</td>
<td>payroll deductions.</td>
</tr>
<tr>
<td><strong>Pre-Tax Payment</strong></td>
<td>Asahi Kasei Plastics North America, Inc. 900 E. Van Riper Fowlerville, MI 48836 517-223-2000</td>
<td>Self-funded</td>
</tr>
<tr>
<td><strong>Health Care Flexible Spending Account</strong></td>
<td>Infinisource EIN: 38-2976613 Please refer to the benefit program booklet for the address, phone number, and claim filing and appeal procedures. 15 East Washington Street Coldwater, Michigan 49036 <a href="http://www.infinisource.net">www.infinisource.net</a> (866) 320-3040</td>
<td>Self-funded Benefit contributions are required. You pay your benefit contributions on a pre-tax basis through payroll deductions.</td>
</tr>
<tr>
<td><strong>Dependent Care Flexible Spending Account</strong></td>
<td>Infinisource EIN: 38-2976613 Please refer to the benefit program booklet for the address, phone number, and claim filing and appeal procedures. 15 East Washington Street Coldwater, Michigan 49036 <a href="http://www.infinisource.net">www.infinisource.net</a> (866) 320-3040</td>
<td>Self-funded Benefit contributions are required. You pay your benefit contributions on a pre-tax basis through payroll deductions.</td>
</tr>
<tr>
<td><strong>Employee Assistance Program</strong></td>
<td>Please refer to the benefit program booklet for the address, phone number, and claim filing and appeal procedures.</td>
<td>Self-funded</td>
</tr>
<tr>
<td><strong>COBRA Administration for all Group Health Plans (Medical, Dental, Vision, Health FSA and EAP)</strong></td>
<td>Infinisource EIN: 38-2976613 15 E. Washington Street PO Box 889 Coldwater, MI 49036 <a href="http://www.infinisource.net">www.infinisource.net</a> (866) 320-3040</td>
<td>You are required to pay the full cost of the applicable COBRA premium, plus a 2% administration fee</td>
</tr>
</tbody>
</table>
### APPENDIX A – BENEFIT PROGRAM INFORMATION

#### PARTICIPATING EMPLOYERS:

<p>| | |</p>
<table>
<thead>
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</table>
| 1. Asahi Kasei Plastics North America, Inc. (APNA)  
900 E. Van Riper  
Fowlerville, MI 48836 | 2. Sun Plastech Inc. (SPI)  
1055 Parsippany Blvd., Suite 205  
Parsippany, NY 07054 |
| 3. Asahi Kasei BioProcess (AKB)  
1855 Elmdale Avenue  
Glenview, IL 60026 | 4. Asahi Kasei Medical America, Inc. (AKMA)  
3570 Winchester Rd, Ste. 101  
Memphis, TN 38118 |
| 5. Crystal IS, Inc. (CIS)  
70 Cohoes Avenue  
Green Island, NY 12183 | 6. Asahi Kasei America, Inc. (AKA)  
535 Madison Avenue, 33rd Floor  
New York, NY 10022 |
| 7. Asahi Kasei Micro Semiconductor, Inc. (AKMS)  
1731 Technology Drive, Ste: 500  
San Jose, CA 95110 | 8. Asahi Kasei Pharma America Corp (AKPA)  
200 Fifth Ave.  
Waltham, MA 02451 |
<table>
<thead>
<tr>
<th>Applies to the following participating employers:</th>
<th>Benefit Program</th>
<th>Eligibility</th>
<th>Termination / When Coverage Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>- APNA</td>
<td>Medical - PPO 2 Plan - PPO 3 Plan - Consumer Driven Health Plan Prescription Drugs (Combined with the medical plans listed above.)</td>
<td>Employees and their eligible dependents become covered for this benefit program on the first day of the month following 30 days of continuous full-time employment. You may enroll: • Your legal spouse • Your same or opposite-sex domestic partner, as defined by our domestic partner affidavit • Your or your spouse’s children until the end of the calendar year they turn 26. • Your or your spouse’s children until any age if they are disabled as defined by the medical carrier.</td>
<td>Eligibility for this benefit program terminates at the end of the month in which you terminate employment with the Company. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims, etc. Coverage for your spouse and dependents ends when your coverage ends. Their coverage will also cease for other reasons specified in the booklets, such as divorce, dependent attains age limit, dependent gets married, etc. Benefits will also cease for employees, spouses and dependents upon termination of the benefit programs under the Plan. Coverage for children dependents will terminate at the end of the year following the date your dependent no longer meets the eligibility requirements.</td>
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<tr>
<td>- AKB</td>
<td>Dental Vision Pre-Tax Payment</td>
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<tr>
<td>- AKA – PPO 2 only; not eligible for PPO 3</td>
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<tr>
<td>- AKMA – PPO 2 only; not eligible for PPO 3</td>
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<tr>
<td>- SPI - PPO 2 only; not eligible for PPO 3</td>
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<td>- CIS</td>
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<td>- AKMS - PPO 2 only; not eligible for PPO 3</td>
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<tr>
<td>- AKPA - PPO 2 only; not eligible for PPO 3</td>
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<tr>
<td>- APNA</td>
<td>Life and Accidental Death &amp; Dismemberment (AD&amp;D) – Basic Coverage</td>
<td>Employees become covered for this benefit program on their date of hire.</td>
<td>Eligibility for this benefit program terminates at midnight on the day in which you terminate employment with the Company. Coverage may also terminate if your hours drop below the required eligibility threshold, or if you submit false claims, etc.</td>
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<tr>
<td>- AKB</td>
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<td>- AKMA</td>
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## APPENDIX B – ELIGIBILITY & FUNDING INFORMATION

<table>
<thead>
<tr>
<th>Benefit Program</th>
<th>Eligibility</th>
<th>Termination / When Coverage Ends</th>
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<tbody>
<tr>
<td>Life - Optional Coverage</td>
<td>Employees and their eligible dependents become covered for this benefit program on the first day of the month following 30 days of continuous full-time employment</td>
<td>Eligibility for this benefit program terminates at midnight on the day in which you terminate employment with the Company. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims, etc. Coverage for your spouse and dependents, where applicable, ends when your coverage ends. Their coverage will also cease for other reasons specified in the booklets, such as divorce, dependent attains age limit, dependent gets married, etc. Benefits will also cease for employees, spouses and dependents upon termination of the benefit programs under the Plan. <strong>Coverage for children dependents will terminate at the end of the month</strong> following the date your dependent no longer meets the eligibility requirements.</td>
</tr>
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<td>Accidental Death &amp; Dismemberment - Optional Coverage</td>
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<tr>
<td>APNA</td>
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<td>AKMS</td>
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<tr>
<td>AKPA</td>
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</table>

<p>| Employee Assistance Program | Employees and their eligible dependents become covered for this benefit program on the first day of the month following 30 days of continuous full-time employment | Eligibility for this benefit program terminates at midnight on the day in which you terminate employment with the Company. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims, etc. Coverage for your spouse and dependents, where applicable, ends when your coverage ends. Their coverage will also cease for other reasons specified in the booklets, such as divorce, dependent attains age limit, dependent gets married, etc. Benefits will also cease for employees, spouses and dependents upon termination of the benefit programs under the Plan. <strong>Coverage for children dependents will terminate at the end of the year</strong> following the date your dependent no longer meets the eligibility requirements. |
| APNA | | |
| AKB | | |
| AKMA | | |
| AKA | | |
| SPI | | |
| CIS | | |
| AKMS | | |
| AKPA | | |</p>
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<th>Benefit Program</th>
<th>Eligibility</th>
<th>Termination / When Coverage Ends</th>
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</thead>
<tbody>
<tr>
<td>☑ APNA  ☑ AKB  ☑ AKMA  ☑ AKA  ☑ SPI  ☑ CIS  ☑ AKMS  ☑ AKPA</td>
<td>Health Care Flexible Spending Account Dependent Care Flexible Spending Account</td>
<td>Employees become covered for this benefit program on the first day of the month following 30 days of continuous full-time employment</td>
<td>Eligibility for this benefit program terminates at midnight <em>on the day</em> in which you terminate employment with the Company. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims, etc. Coverage for your spouse and dependents, where applicable, ends when your coverage ends. Benefits will also cease for employees, spouses and dependents upon termination of the benefit programs under the Plan.</td>
</tr>
<tr>
<td>☑ APNA  ☑ AKB  ☑ AKMA  ☑ AKA  ☑ SPI  ☑ CIS  ☑ AKMS  ☑ AKPA</td>
<td>Long Term Disability</td>
<td>Employees become covered for this benefit program on their date of hire.</td>
<td>Eligibility for this benefit program terminates at midnight <em>on the day</em> in which you terminate employment with the Company. Coverage may also terminate if your hours drop below the required eligibility threshold, or if you submit false claims, etc.</td>
</tr>
<tr>
<td>☑ APNA  ☑ AKB  ☑ AKMA  ☑ AKA  ☑ SPI  ☑ CIS  ☑ AKMS  ☑ AKPA</td>
<td>Short Term Disability – insured</td>
<td>Employees become covered for this benefit program on their date of hire.</td>
<td>Eligibility for this benefit program terminates at midnight <em>on the day</em> in which you terminate employment with the Company. Coverage may also terminate if your hours drop below the required eligibility threshold, or if you submit false claims, etc.</td>
</tr>
<tr>
<td>☑ APNA  ☑ AKB  ☑ AKMA  ☑ AKA  ☑ SPI  ☑ CIS  ☑ AKMS  ☑ AKPA</td>
<td>Short Term Disability – insured</td>
<td>Employees become covered for this benefit program on their date of hire.</td>
<td>Eligibility for this benefit program terminates at midnight <em>on the day</em> in which you terminate employment with the Company. Coverage may also terminate if your hours drop below the required eligibility threshold, or if you submit false claims, etc.</td>
</tr>
</tbody>
</table>
### Short Term Disability – self-funded (advice-to-pay)

Employees become covered for this benefit program on their date of hire.

Eligibility for this benefit program terminates at midnight **on the day** in which you terminate employment with the Company. Coverage may also terminate if your hours drop below the required eligibility threshold, or if you submit false claims, etc.