LUTHERAN SENIOR SERVICES BENEFITS PLAN

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INTRODUCTION

THIS EMPLOYEE BENEFIT PLAN is formally known as the Lutheran Senior Services Benefits Plan (the "Plan").

The purpose of the Plan is to consolidate the multiple insured or self-insured health and welfare benefit plans sponsored and maintained by the Employer into a single, comprehensive health and welfare plan, for ease of administration and reporting.

This Plan is effective January 1, 2018, provided that certain provisions may have a different effective date as described elsewhere in the Plan.

This Plan will be maintained for the exclusive purpose of providing benefits to Eligible Employees and, where applicable, their Dependents, and is intended to comply with all applicable laws, including the Code and ERISA.

ARTICLE I
DEFINITIONS

The following terms will have the following meaning when used in this Plan, unless a different meaning is clearly required by the context. Capitalized terms are used throughout the Plan for terms defined by this and other sections.

Affiliated Employer

"Affiliated Employer" means any entity that is affiliated with the Employer or any entity that is part of a group of entities that includes the Employer and constitutes: (a) a controlled group of corporations (as defined in Code Section 414(b)); (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Code Section 414(c)); (c) an affiliated service group within the meaning of Code Section 414(m); or (d) any other entity required to be aggregated with the Employer pursuant to regulations under Code Section 414(o). Any Affiliated Employers participating in the Plan are listed in the Participating and Affiliated Employer Appendix.

Appendix

"Appendix" or "Appendices" means each of the appendices to the Plan. Each Appendix and any document included or incorporated in the Appendices will be considered a part of the Plan. Any Appendix may be amended by the Plan Sponsor at any time for any reason without consent of any person, except as otherwise provided by law.

Claimant

"Claimant" means an Employee, Dependent or beneficiary who has had a claim for benefits denied in whole or in part by the Plan, or is otherwise adversely affected by an action of the Plan Administrator. Where required or applicable, the term also includes a person (including but not limited to an individual, estate or trust) authorized, whether by the Claimant or by law, to act on the Claimant's behalf. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and including all regulations issued under that act.

Code

"Code" means the Internal Revenue Code of 1986, as amended, and including all regulations issued under that law.

Component Document and Component Program

"Component Document" means a written document identified in the Appendices and incorporated in this Plan by reference. "Component Program" means the program of benefits described in a Component Document.

Covered Individual

"Covered Individual" means an Eligible Employee or eligible Dependent who elects coverage under the Plan and who has not for any reason become ineligible to participate in the Plan. Where required or applicable, the term also includes a person (including but not limited to an individual, estate or trust) authorized, whether by the Covered Individual or by law, to act on the Covered Individual's behalf.

Dependent

An individual is a "Dependent" of an Eligible Employee with respect to a benefit provided under this Plan if the person is classified as a "Dependent" under the Component Document that describes the benefit and the classes of persons eligible for the benefit.

Eligible Employee

"Eligible Employee" means any Employee who meets the eligibility requirements under a Component Program. As described in a Component Document, an Eligible Employee also includes proprietors, partners, corporate officers and directors, and retirees whether or not they are compensated by salary or wages. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of this Plan to which he meets the eligibility requirements of a Component Program.

Employee

"Employee" means any individual who is employed by an Employer, but does not include any of the following (unless specifically included as an "Employee" under a Component Document):

(a) individuals classified and treated by an Employer as independent contractors; however, if an individual classified and treated as an independent contractor is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, the individual will not be considered an Employee until the day after the final determination that the individual is not an independent contractor; and

(b) nonresident aliens who receive no United States source income from an Employer.

If an individual listed in one or more subsections above is specifically included as an "Employee" under a Component Document, he will be considered an Employee under this Plan with respect to the benefit described within that Component Document only, and not necessarily with respect to other benefits under this Plan described in other Component Documents.

However, if, for any period of time, an individual has not, on the Employer's books and records, been treated as a common law employee of the Employer (or "full-time" common law employee under the Employer's policy for determining full-time employees under PPACA where eligibility for coverage under a Component Program depends on full-time status), and a court or government agency subsequently makes a determination that the individual was in fact a common law employee during that period of time, the subsequent determination shall not entitle the individual to any retroactive rights under the Plan, unless this Plan is amended to supply the retroactive rights, and the individual's prospective rights under the Plan shall be determined solely in accordance with the terms of the Plan.

Employer

"Employer" means the Plan Sponsor, with respect to its Eligible Employees, and any Affiliated Employers that are approved by the Plan Sponsor to participate in this Plan with respect to their Eligible Employees.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations issued under that act.

FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended, and including all regulations issued under that act.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and including all regulations issued under that act.

Plan

"Plan" means this Lutheran Senior Services Benefits Plan, as amended from time to time.

Plan Administrator

"Plan Administrator" means the person or entity authorized to administer the Plan pursuant to Article V.

Plan Sponsor

"Plan Sponsor" means Lutheran Senior Services, or any successor in interest.

Plan Year

"Plan Year" means the 12-month period beginning each January 1, and ending the ensuing December 31.

PPACA

"PPACA" means the Patient Protection and Affordable Care Act of 2010, as amended, and including all regulations and other guidance under that act.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations issued under that act.

ARTICLE II
PARTICIPATION

2.1 Eligibility and Enrollment

(a) Eligibility

Any Eligible Employee or eligible Dependent under a Component Program will be considered a Covered Individual in this Plan when the individual acquires coverage for the benefits under the provisions of the relevant Component Document. However, in no event may an Eligible Employee or Dependent participate in this Plan with respect to a particular benefit provided under a Component Program until the date specified in the relevant Component Document. Other eligibility rules may be reflected in the Component Documents themselves, or other documents.

(b) Enrollment

An Eligible Employee may elect participation in this Plan for himself and for any eligible Dependent by completing the appropriate enrollment forms when the Eligible Employee or Dependent, as the case may be, first becomes eligible under the provisions of a Component Document to participate in any or all the benefits described in Article III. If an Eligible Employee (on behalf of himself or an eligible Dependent) does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, he may not elect to participate (or elect to participate in those benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 and any change in enrollment rules provided under a Component Document or a cafeteria plan under Code Section 125.

2.2 Compliance with HIPAA

With respect to those benefits subject to HIPAA, the Plan will comply with HIPAA's special enrollment and nondiscrimination provisions. To the extent HIPAA is applicable, the Plan will not establish a rule for eligibility or set any premium or contribution rate based on whether the Employee is actively at work (including whether

the Employee is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated as being actively at work, as described in the HIPAA portability rules. See also Article IX.

2.3 Termination of Participation

Participation by a Covered Individual in this Plan will terminate when the individual is no longer covered for any benefit provided by any Component Program.

Generally, participation in a benefit provided under a Component Program will terminate as provided in the relevant Component Document. However, unless expressly provided to the contrary in a relevant Component Document, coverage of any individual under a Component Program may be terminated where the Plan Administrator determines that (i) the individual is ineligible for coverage; (ii) enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a misrepresentation pertaining to the individual; (iii) the individual failed to supply information reasonably requested by the Plan Administrator; (iv) premiums were not timely paid by or on behalf of the individual; (v) the individual failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or (iv) for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the individual (or any other person who acts or fails to act on behalf of the individual). Where a Dependent is disenrolled due to any conduct listed above, the Plan Administrator may in its discretion disenroll the disenrolled Dependent's Eligible Employee and one or more of the Eligible Employee's other Dependents where it appears those individuals were complicit in the misrepresentation. Where an Eligible Employee is disenrolled due to any conduct listed above, however, all enrolled Dependents will also be disenrolled.

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively. Coverage may also be terminated retroactively to the date of (as applicable) the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premium, to the date of the individual's enrollment or, if later, the date the individual became ineligible. However, with respect to Component Programs subject to the PPACA, coverage shall be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), or to the extent otherwise permitted by the PPACA or guidance issued under the PPACA (including but not limited to failure to timely pay required premiums or contributions), and upon appropriate notice to the individual as may be required under the PPACA.

2.4 Continuation Coverage Rights

(a) Health Care Coverages

Certain health care coverages under this Plan may be subject to coverage continuation rights under COBRA, or similar state or federal law. Where that is the case, the coverage continuation rights are described in the relevant Component Document. A former Covered Individual who is eligible to, and elects to, continue coverage under the applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law. See also Article X.

(b) FMLA

If participation in health care benefits offered through this Plan would terminate due to the Eligible Employee taking an FMLA leave of absence, eligibility for the health care benefits will be continued for the lesser of: (i) the period of the leave, or (ii) the maximum period of leave required under FMLA. However, other provisions of this Plan or an Employer's employment policies may provide for more generous continued eligibility. Provided, however, coverage for the health care benefits will continue only as long as any required Employee contributions are timely made. Employees on FMLA leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during

a period of FMLA leave to the same extent as the benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

If participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, eligibility for the health care benefits will be continued for the lesser of: (i) the period of leave, or (ii) 24 months. Provided, however, coverage for the health care benefits will continue only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than 31 days must make the same contribution as is required for active Employees; Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

(d) State Mandated Continuation Coverage Rights

In addition to the continuation coverage rights discussed above, some states and localities provide additional continuation coverage rights, which the Plan will comply with to the extent applicable.

ARTICLE III
BENEFITS

Benefits Incorporated by Reference

The benefits offered under this Plan are set forth in the Benefit Program Appendix attached to this document.

Each Covered Individual may elect to receive coverage for the benefits offered under this Plan, subject to any additional eligibility conditions provided under the relevant Component Program. The terms, conditions and limitations of benefits offered under this Plan are contained in the Component Documents referenced in the Benefit Program Appendix, and which are incorporated in this Plan in full, as amended from time to time. The benefits, and the method of providing the benefits, may change from time to time and will be reflected in the Component Documents.

ARTICLE IV
FUNDING

4.1 Contributions

The benefits described in Article III will be funded by Employer contributions or Employee contributions, or a combination of both, as determined from time to time by the Employer. Contributions will be paid to an insurance carrier, other third-party administrator, or with respect to a self-funded, self-administered benefit, amounts will be paid directly to or on behalf of a Covered Individual.

If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the PPACA), allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Program (a "Recovery"), whether the Recovery is paid in cash, or affected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan. Instead, the Recovery amount will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Covered Individuals for coverage under the Plan and will not otherwise be shared with Covered Individuals. If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the Employer may not retain the excess amount; instead, it will be treated as an asset of the Plan to the extent required by applicable law.

4.2 Employee Contributions

Any Employee contributions may be deducted from an Eligible Employee's wages on a pre-tax basis (or after-tax basis if permitted by the Employer). All Employee contributions will be

subject to the policies of the Employer, the terms and conditions of the relevant Component Documents and any cafeteria plan maintained by the Employer pursuant to Code Section 125. Additionally, all Employee contributions will be forwarded by the Employer to an insurance carrier or other third-party administrator; however, with respect to benefits that are paid directly by the Employer, amounts will be collected by the Employer and paid directly to or on behalf of a Covered Individual.

With respect to self-insured benefits provided under the Plan, contributions from a Covered Individual will be deemed to be applied first to the payment of benefits. The intent of this provision is to establish that, in a case where contributions from all Covered Individuals do not exceed the amount of self-insured benefits paid under the Plan, any administrative expenses related to the self-insured benefits will be deemed paid other than from contributions from the Covered Individuals.

ARTICLE V
ADMINISTRATION

5.1 Plan Administrator

The Plan Sponsor is the Plan Administrator of this Plan. The Plan Sponsor may delegate some or all of its duties and authority as Plan Administrator to one or more employees, to a committee appointed by the Plan Sponsor, to a third-party claims administrator, or to other persons as the Plan Sponsor deems appropriate. With respect to the duties and authority of each Component Program, the Plan Sponsor may delegate the duties and authority of different Component Programs to different persons.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the provisions of a Component Document, retains the duties and responsibilities described below for itself or any other third-party (other than the Plan Sponsor), the following will be the Plan Administrator's duties and responsibilities:

(a) Administrative Duties

The Plan Administrator will administer the Plan consistent with the nondiscrimination rules described later in this Article, for the exclusive purpose of providing benefits to Eligible Employees, their Dependents and beneficiaries. The Plan Administrator will perform all the necessary duties to supervise the administration of the Plan, and to control the Plan's operation in accordance with the provisions of this Plan, including, but not limited to, the following:

(i) make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;

(ii) interpret the provisions of the Plan and determine any question arising under the Plan, or in connection with the administration or operation of this Plan, including questions of fact;

(iii) determine all considerations affecting the eligibility of any individual to be or become a Covered Individual;

(iv) determine eligibility for and amount of benefits for any Covered Individual;

(v) authorize and direct all disbursements of benefits under the Plan; and

(vi) authorize the recovery of benefit payments made in error.

(b) General Authority

The Plan Administrator will have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact related to this Plan. Any interpretation, construction or action by the Plan Administrator with respect to the Plan and its administration will be conclusive and binding upon all affected parties and persons, subject to

the exclusive appeal procedures set forth in Sections 5.7 and 5.8.

5.3 Forms

All forms and other communications from any Eligible Employee or other person to the Plan Administrator required or permitted under the Plan shall be: (i) in the form prescribed from time to time by the Plan Administrator; (ii) submitted electronically or delivered as specified otherwise by the Plan Administrator; (iii) deemed to have been given and delivered to the location specified by the Plan Administrator; and (iv) deemed to have been given and delivered to the Plan Administrator only upon actual receipt. Each Covered Individual will file on a form such pertinent information as the Plan Administrator may specify. However, the provisions of the Component Document provide for different or contrary rules and are permitted by law, the provisions of a Component Document will control with respect to forms and other communications to the Plan Administrator to the extent.

5.4 Examination of Documents

The Plan Administrator will make available to each Covered Individual or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. If a Covered Individual or beneficiary requests copies of Plan documents, the Plan Administrator may charge a reasonable amount to cover the cost of furnishing the copies.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets will be segregated for the purposes of providing benefits under the Plan unless a separate trust has been established for the Plan. The Employer will pay benefits under this Plan out of its general assets, to the extent the benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator will file or cause to be filed within the time prescribed by law or regulation all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority. Further, the Plan Administrator will furnish within the time prescribed by law or regulation the reports, statements or other documents to Covered Individuals and beneficiaries as required by a federal or state statute, agency or authority.

5.7 Claims Procedure

A Covered Individual or beneficiary will apply for Plan benefits in writing on a form provided by the Plan Administrator, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the relevant Component Document. Claims will be evaluated by the Plan Administrator, or other person or entity specified in the relevant Component Document, and will be approved or denied in accordance with the provisions of this Plan, including the relevant Component Document.

The following claims procedures will apply, but only to the extent a relevant Component Document does not apply at least as extensive procedures. If the claim and appeal rules in this document apply, they will be construed and applied in a manner consistent with applicable federal regulations as in effect on the date the claim was received:

(a) Notice of Action

Any time a claim for benefits receives an adverse determination, the Claimant will be given written notice of the action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, the Claimant will be notified of the

approval and provided sufficient information to understand the import of the approval.

An "adverse determination" means either (i) a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a benefit, where the action is based on a determination of an individual's eligibility, (ii) a determination that a benefit is not a covered benefit, (iii) the imposition of an exclusion or limitation, or (iv) a determination that a benefit is experimental, investigational or not medically necessary or appropriate. An adverse determination includes retroactive rescission of coverage (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions).

(b) Categories of Claims, "Applicable Periods," and Extensions

(1) "Urgent" Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously, the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim. The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. Whether a claim involves "urgent care" (as defined in applicable federal regulations) will be determined by the Claimant's attending physician, and the Plan will defer to the judgment of the Claimant's physician.

If the Plan cannot render a decision within this 72-hour timeframe because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (i) the Plan's receiving the required information, or (ii) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator must notify the Claimant of the Plan's benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal. Other requirements apply to the processing of appeals by health care coverage subject to the PPACA. See Section 5.8 below.

(2) "Pre-Service" Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that requires advance approval under the provisions of the relevant Component Document. The "applicable period" for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the applicable period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator must notify the Claimant within the initial 15-day applicable period of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within the initial 15-day applicable period because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim. The Claimant then must be given at least 45 days from receipt of the notice of extension to provide the required information. The Plan has 15 days from the date of receiving the Claimant's additional information to render

its decision. The Claimant may agree to extend these deadlines.

(3) "Concurrent" Health Care Claims

A concurrent health care claim may be either an urgent care claim, or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Claimant to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan during the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided in a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision provided in paragraph (d) below before the Plan may terminate the treatment. Coverage must continue during the pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.

(4) "Post-Service" Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the applicable period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator must notify the Claimant within the initial 30-day applicable period of the reason for the extension and the date the Plan expects to render its decision.

If the Plan cannot render a decision within the initial 30-day applicable period because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim. The Claimant then must be given at least 45 days from receipt of the notice of extension to provide the required information. The Plan has 30 days from the date of receiving the Claimant's additional information to render its decision. The Claimant may agree to extend these deadlines.

(5) Disability Benefit Claim

The "applicable period" for a disability benefit claim is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two 30-day extensions, but the Plan Administrator must notify the Claimant of the need for the extension prior to the beginning of any extension period.

(6) Other Claims

The "applicable period" for a benefit claim not described in subsections (1) to (5) above is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator must notify the Claimant of the need for the extension prior to the beginning of any extension period.

(7) Special Rule for Retroactive Health Care Coverage Rescissions

Where health care coverage subject to the PPACA is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), in addition to any other notice that may be required by these provisions, the Plan Administrator will supply

written notice of the rescission to each affected Covered Individual not fewer than 30 days in advance of the date the Plan takes action to actually rescind the coverage.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of the adverse determination must be provided to the Claimant. Generally, the notice must be written or electronic. However, oral notice is permitted with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three days after the oral notice is provided.

The notice must include the following:

(i) the specific reason or reasons for the adverse determination;

(ii) reference to the specific Plan provisions on which the determination is based;

(iii) if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why the information is needed;

(iv) a description of the Plan's review procedures, including the Claimant's right to bring a civil action under ERISA Section 502(a);

(v) (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination, or a statement that it will be provided without charge upon request;

(vi) (for health care and disability claims) if the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

(vii) in the case of an adverse determination involving urgent care, a description of the expedited review process available to urgent care claims.

(d) Right to Request Review

A Claimant will have the right to request review by the Plan Administrator. The request must be in writing, and must be made within 180 days (for health care and disability benefit claims), or 60 days (for other claims), after the Claimant is advised of the Plan Administrator's action. If written request for review is not made within the 180-day (or 60-day, as the case may be) period, the Claimant will forfeit his right to review. The Claimant may review all pertinent documents and submit issues and comments in writing.

(e) Review of Claim

Following a Claimant's request for review as provided in paragraph (d) above, the Plan Administrator will then review the claim. The person or entity that reviews the claim must be a named fiduciary under the Plan. In the case of reviews of health care or disability claims, the person or entity that reviews the claim may not be the same person, or a person subordinate to the person, who initially decided the claim. If in the case of a health care or disability claim where the adverse determination was based on medical judgment, the person handling the appeal must consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved in the claim, and the professional may not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary, and will issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on appeal must be made within (I) 72 hours for a claim involving urgent health care, (II) 30 days for a pre-service health care claim, (III) 45 days for a disability claim, or

(IV) 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit. The time period for a decision on appeal begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on appeal may be delayed for up to 45 days in the case of a disability benefit claim, or 60 days in the case of a claim other than for a disability benefit, where special circumstances require the delay, and the delay is permitted by applicable federal regulations. The Plan Administrator will provide notice of, and the reason for, the extension to the Claimant prior to the end of the decision on appeal.

A copy of the decision will be furnished to the Claimant. The decision will set forth:

(i) the specific reason or reasons for the adverse determination;

(ii) reference to the specific Plan provisions on which the determination is based;

(iii) a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;

(iv) a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under ERISA Section 502(a);

(v) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

(vi) if the adverse determination is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the provisions of this Plan to the Claimant's medical circumstances, or a statement that the explanation will be provided without charge upon request; and

(vii) the following statement: "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 U.S. Department of Labor Office and your State insurance regulatory agency." (However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).)

The decision will be final and binding upon the Claimant and all other persons involved, except to the extent otherwise provided under applicable law.

(f) <u>Additional Rules Applicable to Disability Claims</u>

The following additional rules will apply to any claim or review of a denied claim for disability benefits submitted on or after April 2, 2018 (or a later effective date prescribed by Department of Labor Regulations).

(i) All written notices will be provided in a culturally and linguistically appropriate manner, and will include the following:

- a statement that a copy of all documents, records and other information relevant to the claim is available to the Claimant, free of charge, upon request;
- a discussion of the Plan's decision, including (for example) an explanation of the basis for disagreeing with or not following the views of any disability determination regarding the Claimant by the

Social Security Administration, health care professionals, or vocational professionals;

- if the denial is based on medical necessity, experimental treatment, or other similar exclusions or limitations, an explanation of the scientific or clinical judgment used in the decisions, or a statement that an explanation will be provided free of charge upon request; and

- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the denial, or a statement that they do not exist.

(ii) The claim will be decided in a way that ensures the independence and impartiality of Plan decision makers involved in the review process, including claims processors or medical experts) and avoids any conflicts of interest as set forth in Section 2560.503-1 of the Department of Labor regulations.

(iii) No deference will be afforded to the initial adverse determination, and the review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(iv) In deciding an appeal that is based in whole or in part on a medical judgment, the Plan decision maker will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(v) Any medical or vocational experts whose advice was obtained on behalf of

(vi) Any health care professional consulted in making a medical judgment will be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual.

(vii) Any new or additional evidence considered, relied on, or generated by the Plan or decision maker in connection with a review of the denied claim will be disclosed to the Claimant as soon as possible, and in all cases before the Plan can issue an adverse benefit determination.

Any new or additional rationale relied on by the Plan or decision maker in connection with the review of the denied claim will be disclosed to the Claimant as soon as possible and in all cases before the Plan can issue an adverse benefit determination.

5.8 Additional Requirements Health Care Coverage Subject to the PPACA

For health care claims under health care coverage subject to the PPACA, the following additional rules apply.

(a) Additional Requirements for Notice of Initial Adverse Determination and Notice of Final Action on Internal Appeal

Any notice of initial adverse determination or notice of final action on an internal review of an adverse determination must include the following additional information:

(i) the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings (the Plan will supply this information related to the diagnosis and treatment codes as soon as practicable following a request, and will not consider the request to be a request for an internal appeal or, as applicable, external review);

(ii) the standard, if any, used in denying the claim in whole or in part (i.e., a discussion of an applied "medical necessity" standard);

(iii) a description of the available internal and external appeals procedures, including information about how to initiate an appeal; and

(iv) the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under the PPACA to assist individuals with the internal claims and appeals and external review procedures.

The notices described above must be supplied in a "culturally and linguistically appropriate" manner, pursuant to and to the extent required by applicable federal regulations.

(b) Additional Requirements Related to Access to Information Pending Decision on Appeal

In connection with any appeal of an adverse determination, the Claimant will have the right to examine the Claimant's claim file, and to present evidence and testimony as part of the review process. The Claimant will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an adverse determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow the Claimant an opportunity to respond prior to the decision.

(c) Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether or not the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in applicable federal regulations.

Where the relevant health care coverage is subject to a state insurance law external review requirement that complies with applicable federal regulations (or is deemed to comply during any transition period under the applicable federal regulations), the state review requirement will apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state insurance law external review requirement, or is subject to a state review requirement that does not meet federal regulatory requirements (taking into account any period of deemed compliance during a transition period provided for under applicable federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(1) A Claimant may file a request for external review within four months of receipt of notice of an adverse determination (to the extent permitted by applicable law; however, the Plan may require the Claimant to exhaust any reasonable internal appeal process). For this purpose, and to the extent permitted by applicable federal regulations, an "adverse determination" means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.

(2) Within five business days following receipt of the request for external review, the Plan will determine whether:

(i) the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is a for a post-service claim);

(ii) the adverse determination was not due to ineligibility of the Claimant;

(iii) the Claimant exhausted any required internal appeal process; and

(iv) the Claimant has provided all information required.

(3) The Plan Administrator will issue notice to the Claimant within one business day after the Plan's preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe

information that is needed and allow the Claimant to complete or perfect his request within the four-month filing period described above or 48 hours, whichever is later.

(4) If the request for external review is appropriate, the Plan will refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO will conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan's decision, the Plan will provide coverage or payment upon receipt of notice of the IRO's decision, without delay and without regard to the Plan's intention to seek judicial review.

(5) The Plan will make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination and where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(d) No Conflicts of Interest

The Plan will adjudicate claims in a manner ensuring the independence and impartiality of those involved in the decision making. For example, the Plan may not hire, promote, provide incentives to, or terminate the employment of, individuals based on their support of a denial of benefits or on the number of claims denied.

5.9 Expenses

Unless specified otherwise in a Component Document, the Employer will pay all reasonable expenses that are necessary to operate and administer the Plan.

5.10 Bonding and Insurance

To the extent required by law, every fiduciary of the Plan and every person handling Plan funds will be bonded. The Plan Administrator will take the necessary steps to assure compliance with applicable bonding requirements. The Plan Administrator may obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

5.11 Nondiscrimination Rules

The Plan will comply with all applicable nondiscrimination rules under the Code and any other applicable law. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate the nondiscrimination testing. Any elections required to be in writing (e.g., the designation of separate testing plans, where disaggregation or aggregation of Component Programs or portions of Component Programs is permitted or required) will be stated from time to time in Appendices to the Plan, to the extent required by applicable law.

5.12 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order with respect to Component Programs that are subject to the Order. For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a child's rights to, or assigns to the child the right to, receive health benefits for which a Dependent is eligible under this Plan, provided the order clearly specifies: (i) the name and last known mailing address of the Eligible Employee, and the name and mailing address of each child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the child); (ii) a reasonable description of the type of coverage to be provided by the Plan to each child, or the

manner in which coverage is to be determined; (iii) the time period to which the order applies; and (iv) meets other legal requirements. A national medical support notice that meets (or, pursuant to applicable federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

The Plan Administrator (or other person or entity specified in the relevant Component Document) after receiving a medical child support order will (i) promptly notify the Eligible Employee and each child (or his legal representative) designated in the order, (ii) evaluate the order, and (iii) approve or deny the order. The notification will contain information that permits each child to designate a representative for receipt of copies of notices that are sent to the child with respect to a medical child support order.

Within 40 business days after receipt of the order (or, in the case of a national medical support notice, the date of the notice) the Plan Administrator (or other person or entity specified in the relevant Component Documents) will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not "qualified," the Plan Administrator (or other person or entity specified in the relevant Component Documents) will send a written copy of the determination to the Eligible Employee and each child (or his legal representative) (or, notify the official of the state agency issuing the order where the official is substituted for the name of the child).

If the Plan Administrator (or other person or entity specified in the relevant Component Documents) determines that the medical child support order is qualified, the Eligible Employee and each child (or his legal representative) must furnish to the Plan Administrator any required enrollment information. In the case of a national medical support notice, the Plan Administrator will: (i) notify the state agency issuing the notice whether coverage is available to the child under the Plan and, if so, whether the child is covered under the Plan, and either the effective date of the coverage, or any steps to be taken by the child (or his legal representative) or an official of the state agency that issued the notice to effectuate such coverage; and (ii) provide the child (or his legal representative) (or, notify the official of the state agency issuing the order where the official is substituted for the name of the child) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

The Eligible Employee or child (or his legal representative) is responsible for notifying the Plan Administrator of the necessary enrollment information within the timeframe specified in the relevant Component Program, but generally, in no more than 45 days following the date the determination was made that the order is a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within 20 days after the Plan Administrator's notice described in the preceding paragraph, the child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the Eligible Employee will be responsible to make any required contribution to pay for the coverage. In no event will coverage provided under a Qualified Medical Child Support Order become effective for a child prior to the date the Order is received by the Plan.

If the Plan Administrator determines or other person or entity specified in the relevant Component Documents) that the medical child support order is not "qualified," a written determination to that effect will be furnished to the Eligible Employee and each child (or his legal representative). The Eligible Employee or the child (or his legal representative) may appeal the determination to the Plan Administrator. Any request for review of a determination must be filed with the Plan Administrator within 60 days after the Plan Administrator issues its original determination.

5.13 Integration of Lifetime Benefit Maximums Under Medical Benefit Options

Notwithstanding anything in this Plan to the contrary, the lifetime benefit dollar maximums (for benefits considered non-essential health benefits under the PPACA) under the Plan's comprehensive medical benefit options are integrated, and lifetime treatment maximums under the Plan's comprehensive medical benefit options are integrated, so that the benefits that are paid by the Plan and applied against the limits reflected in the comprehensive medical benefit option under which a Covered Individual is then enrolled are also applied against the lifetime limits (if any) of each other comprehensive medical benefit option available under the Plan.

The intent of this provision is to prohibit a Covered Individual from enrolling in a different comprehensive medical benefit coverage option and thereby avail himself of the full lifetime non-essential health benefit dollar maximum or lifetime treatment maximum under the option, where the Plan (or any Component Program under the Plan, or any predecessor of that Component Program) has paid comprehensive medical benefits to or on behalf of the Covered Individual under that same or a different comprehensive medical benefit option. This rule will allow for the crediting, against one option's lifetime non-essential health benefit dollar maximum, of the benefits paid under another option, without regard to when the benefits were paid, provided that at the time the benefits were paid the two options were components of the same medical plan.

ARTICLE VI
RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

6.1 Applicability and Special Definitions

The provisions of this Article VI apply to the extent the reimbursement and subrogation provisions of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation provisions of an applicable Component Document supply greater rights, the provisions of the applicable Component Document will apply. For purposes of this Article VI, a law will not be considered an "applicable law" if it is preempted by ERISA.

Additionally, for purposes of this Article VI, the following special definitions will apply:

(a) "Applicable Component Document" means a Component Document the benefits under which are the subject of a reimbursement or subrogation claim by this Plan.

(b) "Covered Individual" means a Covered Individual as defined in Article I, or a participating coverage continuation beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

(c) "Other Plan" includes, but is not limited to, any of the following that provide payments on account of an injury or sickness:

(i) any group, blanket or franchise health insurance, or similar coverage;

(ii) a group contractual prepayment or indemnity Plan, or similar coverage;

(iii) a Health Maintenance Organization (HMO), whether group practice or individual practice association;

(iv) a labor-management trusted Plan, or a union welfare Plan;

(v) an Employer or multiemployer Plan, or Employee welfare benefit Plan;

(vi) a governmental medical benefit program;

(vii) insurance required or provided by statute;

(viii) automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance); or

(ix) settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Other Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs, such as Medicaid, except as otherwise provided in this Plan. The term "Other Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

(d) "Person" means any individual, association, partnership, corporation, or any other organization.

6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the Plan's coordination of benefits provisions have been made under any Other Plans, this Plan will have the right to pay to any Person making the other payments any amounts the Person determines to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts paid by this Plan to Persons making the other payments will be deemed to be benefits paid under this Plan, and to the extent of the payments, this Plan will be fully discharged from liability.

6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Individual has received or is entitled to receive from any Other Plan or Person exceeds (i) the maximum amount necessary to satisfy the intent of this provision, or (ii) under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Individual, Plan, provider or Person to, for or with respect to whom, the payments were made, this Plan will have the right to recover the payments, to the extent of the excess, from among one or more of the following, as the Plan Administrator in its sole discretion may determine:

(a) The Covered Individual.

(b) If the Covered Individual is an eligible Dependent or former eligible Dependent, the Eligible Employee or former Eligible Employee with respect to whom the Covered Individual is or was an eligible Dependent.

(c) Any Other Plan, provider or Person to, for or with respect to whom, the payments were made.

(d) Any insurance company, Other Plan or Person that should have made the payment.

(e) Any other Persons.

Alternatively, the Plan Administrator may set off the amount of the payments, to the extent of the excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Individual, Plans, providers, insurance companies, or other Persons as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Individual, or by a health care provider who treated the Covered Individual, and the Plan Administrator later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to: (i) recover the payment from the Covered Individual or the provider, or part of the payment from both, or (ii) set off the amount of the payment from amounts the Plan may owe in the future to the Covered Individual or the provider, or both. This same rule applies if the Plan makes payment to a Covered Individual or a provider of an expense that is a covered expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Individual as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Individual (or anyone who received payment on behalf of the Covered Individual) from the payment made by the Other Plan or Person, in an amount equal to the lesser of (i) the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Person. This provision will not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Individual's covered expenses.

These reimbursement provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Individual (or any other Person who received payment on behalf of the Covered Individual, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Individual and any other Person, such as the Covered Individual's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any Person (such as the Covered Individual's legal counsel) other than the Covered Individual (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Individual) where the Plan can be made whole entirely from amounts actually received by the Covered Individual (or the Person, such as a parent or legal guardian, who received amounts on behalf of the Covered Individual). This same rule will apply to the Plan's rights to set off as described above.

In addition, where an Other Plan or Person pays compensation to or on behalf of a Covered Individual for an injury or sickness for which an Other Plan or Person is or may be liable, and the Covered Individual incurs (either before or after payment of the compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, the otherwise covered expenses that were either (i) incurred after the date on which the compensation was paid, or (ii) incurred before the date on which the compensation but not paid by this Plan as of that date, will be excluded from coverage under this Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Individual, over the covered expenses which this Plan has already paid for treatment of the injury or sickness.

This Plan will not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Individual in connection with any recovery from any Other Plan or Person, unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Individual, whether in a settlement agreement or otherwise, will not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

6.4 Subrogation

To the extent of benefits paid or payable by this Plan and permitted by applicable law, the Plan will be subrogated to any monies (*i.e.*, "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Individual to whom or on whose behalf this Plan made its payments, or to whom or on whose behalf this Plan's payments are payable. The Plan will not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Individual in connection with any efforts to recover monies from any Other Plan or Person, unless this Plan

agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Individual, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to its subrogation right, all or a portion of the payment.

These subrogation provisions will not be construed to prevent the Plan from obtaining full satisfaction of its subrogation lien from, in the Plan's sole discretion, the Covered Individual (or any other Person who received payment on behalf of the Covered Individual, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Individual and any other Person, such as the Covered Individual's legal counsel.

This Plan will also be subrogated, to the extent of benefits paid under this Plan, to any claim a Covered Individual may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Individual, this Plan may (but will not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Individual's consent. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim, up to the amount of the award or settlement. Any balance remaining will be paid to the Covered Individual as soon as administratively practical. The Plan Administrator may, in its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

6.5 Implementation

The Plan Administrator will determine which of the Plan's rights and remedies is in the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments, or to accept less than full reimbursement, if: (1) this Plan has made, or caused to be made, reasonable, diligent and systematic collection efforts that are appropriate under the circumstances; and (2) the terms of the agreement are reasonable under the circumstances based on the likelihood of collecting the monies in full or the approximate expenses this Plan would incur in an attempt to collect the monies.

6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided in this Plan, if a Covered Individual incurs an injury or sickness under circumstances where compensation may be payable to the Covered Individual by some Other Plan or Person, the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Individual agrees in writing to the following:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Individual has with respect to the injury or sickness;

(b) Promises not to take any action that would prejudice the Plan's subrogation rights;

(c) Promises to reimburse the Plan for any benefits payments to the extent that the Covered Individual receives a recovery from an Other Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Individual whole. This reimbursement must be made within 30 days after the Covered Individual (or anyone on his or her behalf) receives the payment; and

(d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Individual fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator, the Plan will be relieved of any and all legal, equitable or contractual obligation for any

benefits or covered expense incurred by the Covered Individual and each member of the Covered Individual's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision will be construed to prevent application of the Reimbursement provisions above regarding the Plan's exclusion of otherwise covered expenses which have not been paid at the time the Covered Individual receives compensation for the injury or sickness that gave rise to the expenses.

6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled to be reimbursed for benefits it has paid for treatment of a Covered Individual's sickness or injury, and where the Covered Individual receives or is entitled to receive compensation for the sickness or injury from some other source, the Plan will have a constructive trust on the compensation to the extent of the benefits paid by the Plan. The constructive trust will be imposed upon the person or entity then in possession of the compensation.

6.8 Right To Receive And Release Necessary Information

With respect to any Person claiming benefits under this Plan, the Plan Administrator may, without the consent of or notice to any Person, release to or obtain from any insurance company or other Person, any information which the Plan Administrator deems to be necessary for the purposes of determining the applicability of, and implementing the provisions of, this Plan or any Other Plan. Any Person claiming benefits under this Plan will furnish to the Plan Administrator any information as may be necessary to implement this provision.

ARTICLE VII
AMENDMENT AND TERMINATION

7.1 Amendment or Termination

The Plan Sponsor establishes this Plan with the intention that it will be maintained indefinitely. However, the Plan Sponsor reserves the right to amend any or all of the provisions of the Plan, or terminate the Plan or Employer contributions under this Plan, in whole or in part, at any time, for any reason, without consent of any person, and without liability to any person, for the amendment or termination; provided the payment of claims that are incurred at the time of any amendment or termination will not be adversely affected.

Any amendment of the Plan will be made in writing and will be approved by the Plan Sponsor and executed by a duly-authorized representative of the Plan Sponsor, provided that an amendment of any of the Appendices may be made by the Plan Administrator. Because the Plan can only be amended by a written instrument, no person may rely on any oral statements or representations by any other person that attempt or purport to alter the provisions of the Plan, the benefits described in this Summary, or any other written Plan document. Nothing in this Plan will be construed to require continuation of this Plan with respect to existing or future Covered Individuals or beneficiaries.

Any insurer providing benefits under this Plan through a Component Program may amend the insurer's Component Document, to the extent provided in the Component Document.

Where a change to a Component Document affects the information described in one or more Appendix, then the Appendix may be updated in accordance with the change to the Component Document without resorting to the formalities of a formal amendment. For example, if a Component Document is amended or replaced with a similar document (e.g., a group insurance contract is replaced by a similar contract issued by the same or different insurer), or where the claims administrator for a particular Component Program is changed, the Plan Sponsor or Plan

Administrator may, without resorting to the formalities of a formal amendment, replace the Appendices with Appendices reflecting the updated information regarding the Component Document or its issuer.

7.2 Exclusive Purpose of Providing Benefits to Covered Individuals

The Plan Sponsor establishes this Plan for the exclusive benefit of Covered Individuals. No Plan amendment or termination will be made which would cause or permit benefits to be provided other than for the exclusive benefit of Covered Individuals or beneficiaries, unless the amendment is made to comply with federal or local law.

7.3 Surplus Assets After Plan Termination

If a benefit is terminated and surplus assets attributable to that benefit remain after all liabilities regarding the benefit have been paid, to the extent permitted by applicable law and unless otherwise specified in the relevant Component Documents, the surplus will revert to the Employer.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Plan Interpretation

This Plan document, including the attached Appendices and Component Documents incorporated in this Plan by reference, sets forth the provisions of this Plan. This Plan will be read in its entirety and not severed, except as provided in Section 8.8. The provisions of this document will control over the provisions of any Component Document, except to the extent this document expressly provides to the contrary.

8.2 Participation by Affiliated Employers

The Plan Sponsor may permit any of its Affiliated Employers to participate in one or more benefits under the Plan. An Affiliated Employer will be deemed to have adopted the Plan and become an "Employer" under this Plan by making contributions under the Plan.

8.3 Non-Alienation of Benefits

Except as provided in Section 5.12 (Qualified Medical Child Support Orders) or as set below, no benefit, right or interest of any person under this Plan will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment, or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of the person, except as otherwise required by law.

Without limiting the preceding paragraph, a Covered Individual may not assign to any party, including without limitation to a provider of health care services/items, such person's right to benefits under this Plan, nor may the Covered Individual assign any administrative, statutory, or legal rights or causes of action he or she may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights will be void and unenforceable under all circumstances.

A Covered Individual, however, may authorize the Plan to pay any health care benefits to a participating or non-participating provider of benefits under a Component Program. When a Covered Individual authorizes the payment of benefits to a participating or non-participating provider, the Covered Individual authorizes the payment of the entire amount of the benefits due on that claim. A Covered Individual may not interpret or rely upon this discrete authorization or permission to pay any health care or other benefits to a participating or non-participating provider as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of health care services/items.

8.4 No Additional Rights

No person will have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan, the creation of any fund or account, the payment of

benefits, nor any action of the Employer or the Plan Administrator, will be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as in this Plan provided. The Employer expressly reserves the right to discharge any Employee at any time.

8.5 Representations

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

8.6 Notice

All notices, statements, reports and other communications from the Employer to any Employee, or other person required or permitted under the Plan, will be deemed to have been duly given when delivered (including facsimile transmission, email, telex, and telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, the Employee, or other person, at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used in this Plan and where the context will plainly so require, a pronoun will include the opposite gender and the singular will include the plural, and the plural will include the singular.

8.8 Severability

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

8.9 Governing Law

This Plan will be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the State Missouri.

8.10 Disclosure to Covered Individuals

To the extent required by law, each Covered Individual will be advised of the general provisions of the Plan and, upon written request addressed to the Plan Administrator, will be furnished any information requested regarding the Covered Individual's status, rights and privileges under the Plan, as may be required by law.

8.11 Accounting Period

The accounting period for the Plan will be the Plan Year.

8.12 Facility of Payment

In the event any benefit under this Plan will be payable to a person who is under legal disability, or who is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of the benefit to a duly appointed guardian, committee or other legal representative of the disabled or incapacitated person, or in the absence of a guardian or legal representative, to a custodian for the person under a Uniform Gifts to Minors Act, or to any relative of the person by blood or marriage, for the person's benefit. Any payment made in good faith pursuant to this provision will fully discharge the Employer and the Plan of any liability to the extent of the payment.

8.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Individual or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take any other action it deems necessary and equitable to correct any error.

8.14 Workers' Compensation

This Plan is not in place of, and does not affect any requirement for, coverage by a workers' compensation insurance or program; provided, however, the Plan Administrator, in its sole discretion, reserves the right to coordinate the receipt of workers' compensation benefits with any self-insured benefits available under this Plan, and may determine that the workers' compensation benefits shall offset or otherwise reduce the benefits available under this Plan.

8.15 Managed Care Directories

To the extent any Component Document under this Plan provides health benefits under one or more managed care networks, a directory of network providers may be furnished or made available in writing or electronically to each Eligible Employee. However, each Eligible Employee upon written request will receive, at no cost, a written directory of network providers, which may be provided in a separate document.

8.16 Time for Bringing Actions Against the Plan

Notwithstanding any provision in this Plan document or a Component Document to the contrary, no legal action may be brought to recover from or with respect to this Plan (i) prior to the date the Claimant has exhausted all administrative remedies under this Plan and relevant Component Documents, or (ii) after the date that is one year following the date the Claimant has received a final decision on appeal with respect to the claim.

8.17 Newborns' and Mothers' Health Protection Act

With respect to each Component Program that would separately be considered a group health plan within the meaning of ERISA Section 733(a), this Plan will not 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 normal 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 newborn earlier than the above periods. In any case, this Plan will not require that a provider obtain authorization from this Plan for prescribing a length of stay not in excess of the above periods. The coverage under this Section will be subject to all other provisions of the relevant Component Document, such as deductibles, copays, and coinsurance.

8.18 CHIPRA Special Enrollment Rights

With respect to each Component Program that is a group health plan within the meaning of ERISA Section 733(a), this Plan will comply with the Children's Health Insurance Program Reauthorization Act of 2009. This generally means that the Component Program will allow a 60-day special enrollment right for Eligible Employees and their Dependent children under the following two circumstances: (i) termination of coverage due to loss of eligibility under Medicaid or a state-sponsored children's health insurance program ("CHIP"); or (ii) becoming eligible for assistance under Medicaid or CHIP to help pay for coverage under the Component Program.

8.19 Mental Health Parity

Each Component Program that is a group health plan within the meaning of ERISA Section 733(a) will comply with the requirements of the Mental Health Parity Act of 1996, to the extent it is applicable to the Component Program. This generally means that the Component Program will not place annual or lifetime maximums for mental health benefits that are lower than the annual and lifetime maximums for physical health benefits. The coverage under this Section will be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days or outpatient visits.

To the extent any Component Program that is a group health plan within the meaning of ERISA Section 733(a) provides both medical and surgical benefits and mental health benefits or substance use disorder benefits (referred to as a

"Parity-Required Program"), the Component Program will comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008. This generally means that a Parity Required Program: (1) will not impose an annual or lifetime limit on mental health or substance use disorder benefits that is different from any annual or lifetime limit imposed on medical or surgical benefits; (2) will not impose treatment limitations, cost sharing, deductibles, copayments, coinsurance or out-of-pocket requirements on mental health or substance use disorder benefits that are more restrictive than the predominant requirements that apply to substantially all medical or surgical benefits, and no separate such requirements will apply only to mental health or substance use disorder benefits; (3) will not limit mental health or substance use disorder benefits for services from out-of-network providers in a manner different from the limits on medical or surgical benefits; and (4) the criteria for medical necessity determinations for mental health or substance use disorder benefits will be made available to Covered Individuals, beneficiaries, or contracting providers upon request in accordance with applicable regulations, and the reasons for any denial of mental health or substance use disorder benefits will be made available to the Covered Individual on request or as otherwise required in accordance with regulations.

8.20 Women's Health and Cancer Rights

To the extent any Component Program is a group health plan within the meaning of ERISA Section 733(a), the Component Program will comply with the Women's Health and Cancer Rights Act of 1998, which requires the provision of coverage, subject to any deductibles and coinsurance, for breast reconstruction in connection with a mastectomy as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

8.21 Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act prohibits using genetic information to discriminate with respect to health benefits. Therefore, each Component Program that is a group health plan within the meaning of ERISA Section 733(a) is prohibited from (1) restricting enrollment or adjusting premiums based on genetic information; and (2) requiring or requesting genetic information or genetic testing prior to or in connection with enrollment.

8.22 Indemnity of Employees

To the extent any employee or committee of Employees has been appointed to serve as the Plan Administrator, the employer shall indemnify and hold each individual harmless from any and all liabilities or expenses of any kind incurred by the individual in carrying out their administrative responsibilities under the Plan, except to the extent the liabilities or expenses result from the gross negligence or willful misconduct of the individual.

ARTICLE IX
HIPAA PRIVACY PROTECTIONS

9.1 Background

HIPAA imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Individuals remains confidential, subject to limited exceptions in which PHI may be disclosed. PHI means health information (including oral information) that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual's past, present or future physical or mental health

condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

"Electronic Protected Health Information" ("ePHI") is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103. Unless otherwise provided, references in this Article IX to PHI include ePHI.

9.2 Applicability and Effective Date

The rules contained in this Article IX do not apply to the Plan or the Employer until the date the HIPAA Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The HIPAA Regulations only apply to a Component Program that is a group health plan within the meaning of ERISA Section 3(1) and that provide medical care within the meaning of Public Health Service Act Section 2791(a)(2) (e.g., medical, dental and vision care), and only to the extent the benefits are not "excepted benefits" under the HIPAA Regulations. The Plan Administrator may make a "hybrid entity designation" under which it has identified portions of the Plan that engage in functions covered by the HIPAA Regulations, and the portions that do not. To the extent permitted by law, where the Plan includes one or more fully-insured health care benefit Component Programs, and one or more self-insured health care benefit Component Programs, the mere fact that fully-insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully-insured health care benefit (absent the Plan Sponsor's acquisition of PHI with respect to the fully-insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Programs.

9.3 Disclosure of PHI

The Plan may disclose PHI (relating to a Covered Individual) to the Plan Sponsor without permission from the Covered Individual, provided the Plan (or an Employer on behalf of the Plan) provides to Covered Individuals a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Plan Sponsor. However, in no event may the Plan disclose PHI to an Employer without permission from the Covered Individual for purposes of employment-related actions or decisions, or in connection with any other benefit plan of the Employer (although the Plan may disclose summary PHI or enrollment related PHI to the Plan Sponsor, without authorization, as further described below).

The Plan may disclose PHI to the Plan Sponsor, without permission from the Covered Individual and subject to the Plan Sponsor's obligations described below in Section 9.4, for Plan administrative functions, such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administrative function may be disclosed.

In addition to disclosing PHI to the Plan Sponsor to allow the Plan Sponsor to perform Plan administrative functions, the Plan may disclose certain summary health information to the Plan Sponsor, without permission from the Covered Individual, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. The Plan may also disclose enrollment and disenrollment information to the Plan Sponsor without permission from the Covered Individual.

9.4 Obligations of Plan Sponsor Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions, the Plan Sponsor specifically agrees to:

(a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Individual to whom the PHI relates;

(b) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) ensure that any agents, including or subcontractors, to whom it shares or provides PHI received from the Plan agree to these same restrictions and conditions, and agree to implement reasonable and appropriate security measures to protect the ePHI;

(d) not use the PHI for employment-related actions or in connection with any of an Employer's other benefit plans;

(e) report to the Plan any improper uses or disclosures of the PHI, and any security incident with respect to ePHI of which it becomes aware;

(f) provide Covered Individuals access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Individuals an accounting of all disclosures of their PHI by the Plan Sponsor (except for those disclosures with respect to which no disclosure or accounting is required);

(g) make available to appropriate federal authorities the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan;

(h) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Plan Sponsor's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI; and

(i) ensure the adequate separation, between the PHI and persons who have no legitimate need to access such PHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

9.5 Use And Disclosure Of PHI By The Plan Sponsor; Dispute Resolution

When the Plan Sponsor obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to members of the Plan Sponsor's designated HIPAA team, including the Plan Sponsor's human resources and benefits departments, payroll department, and the Plan Sponsor's chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Individual to the Plan Sponsor, will have access to and may use the PHI solely to perform Plan administrative functions that the Plan Sponsor performs for or with respect to the Plan.

The Plan Sponsor may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in Section 9.3 above. The Plan Sponsor may also disclose PHI relating to a Covered Individual, without permission from the Covered Individual, as required or otherwise permitted by law. For example, the law allows PHI to be disclosed, without permission from the Covered Individual, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Individual may, to the extent permitted by local law, be disclosed to the Covered Individual's parent or guardian without permission from minor. There are other situations in which PHI may be disclosed without the Covered Individual's consent. For more information please review the Plan's HIPAA Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Individual or any other person believes that the Plan Sponsor or any of its

agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Plan Sponsor's Privacy Official (contact the Plan Administrator for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which should have already been received (an additional copy is available from the Plan Administrator). If the complaint is filed with the Privacy Official, the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Plan Sponsor's privacy policy and procedure.

ARTICLE X
COVERAGE CONTINUATION RIGHTS

10.1 Background

Covered Individuals have the opportunity to continue their health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. This continuation coverage is as described in COBRA, and is therefore sometimes referred to as "COBRA Continuation Coverage."

10.2 Entitlement And Qualifying Events

Under COBRA, a Covered Individual may elect to continue health coverage if the Covered Individual's coverage would otherwise terminate due to a "qualifying event." Qualifying events are:

(a) A covered Eligible Employee's termination of employment (except for gross misconduct) or reduction in work hours;

(b) Death of the covered Eligible Employee;

(c) Divorce or legal separation of the covered Eligible Employee and his spouse;

(d) A covered Dependent child ceasing to satisfy the Plan's definition of eligible child; or

(e) A covered Eligible Employee's entitlement to Medicare.

10.3 COBRA Qualified Beneficiaries

A COBRA Qualified Beneficiary includes a former covered Eligible Employee, his spouse and Dependent children who is entitled to COBRA Continuation Coverage. In addition to those individuals, a child born to, adopted by, or placed for adoption with, a COBRA Qualified Beneficiary who is a former covered Eligible Employee, during the former covered Eligible Employee's period of COBRA Continuation Coverage, is also a COBRA Qualified Beneficiary.

10.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

(a) Eighteen months for a Covered Individual whose coverage would cease because of a former covered Eligible Employee's termination of employment or reduction in work hours; or

(b) Twenty-nine months (i.e. 18 plus 11) for a disabled COBRA Qualified Beneficiary who:

(1) becomes entitled to the 18 months of continued coverage available after a former covered Eligible Employee's termination of employment or reduction in work hours;

(2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and

(3) notifies the Plan of that disability determination within 60 days after the COBRA Qualified Beneficiary receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of

coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

(c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

(d) Where due to a reduction in hours during a stability period (for example, from full-time to part-time or per diem status) an Employee's eligibility for health coverage will terminate at the end of the stability period, or a subsequent stability period, an Employer's obligation to notify the Plan Administrator of the occurrence of the reduction in hours begins on the date of the loss of coverage, and the end of the maximum COBRA Continuation Coverage period is measured from the date of the loss of coverage rather than from the earlier reduction in hours. The terms "measurement period" and "stability period" shall have the meanings as defined in the Employer's policy for determining full-time employees under PPACA. The foregoing policy, if adopted by the Employer, will be applied on a uniform and consistent basis among all similarly situated Employees.

(e) Special COBRA rules apply to COBRA Continuation Coverage under the health flexible spending account ("FSA"). Notwithstanding the foregoing, the duration for which a COBRA Qualified Beneficiary may purchase COBRA Continuation Coverage under a health FSA depends on a number of factors. In most cases COBRA Continuation Coverage is not available beyond the end of the 12-month FSA coverage period in which the qualifying event occurred. In addition, if at the time of the qualifying event the former Covered Individual received health FSA benefit payments (during the 12-month coverage period) in an amount *exceeding* his contributions to the health FSA for that coverage period, then the former Covered Individual is not eligible for COBRA Continuation Coverage at all under the health FSA.

However, if the maximum amount of benefits available to the former covered Eligible Employee under the health FSA exceeds two times his salary reduction contribution for the year or, if greater, the salary reduction contribution plus $500, COBRA Continuation Coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a COBRA Qualified Beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death) or reduction in hours, or is so disabled during the first 60 days of COBRA Continuation Coverage following the a qualifying event, COBRA Continuation Coverage for that COBRA Qualified Beneficiary (and any other COBRA Qualified Beneficiary affected by the same qualifying event) can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

If a COBRA Qualified Beneficiary is eligible for and chooses COBRA Continuation Coverage, he is eligible for reimbursement for covered claims incurred after the qualifying event but during the same 12-month coverage period in which the qualifying event occurred, in an amount up to the maximum amount of reimbursement selected by the former covered Eligible Employee on his health FSA benefit election form for that 12-month coverage period, *minus* the amount of reimbursements made to the former covered Eligible Employee for the 12-month coverage period up to the date of the qualifying event. If COBRA Continuation Coverage can continue into subsequent 12-month coverage periods (under the rules in the preceding paragraph), the COBRA Qualified Beneficiary must make an election—prior to the beginning of the 12-month coverage period—concerning the benefits he wants to have available for that new 12-month coverage period.

10.5 <u>Special Second Election Period for Certain Trade-Displaced Individuals</u>

Who Did Not Elect COBRA Continuation Coverage

Special COBRA rights apply to certain Eligible Employees who lose health coverage as a result of a qualifying event from termination of employment or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under the Trade Act of 1974. These former covered Eligible Employees are entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the former covered Eligible Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits), or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the former covered Eligible Employee's group health plan coverage ended.

10.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses COBRA Continuation Coverage under these provisions after an former covered Elibible Employee's COBRA qualifying event as a result of termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue COBRA Continuation Coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. In no case will any period of COBRA Continuation Coverage exceed 36 months. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described in Section 10.9. Please note that for the Eligible Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the relevant Component Document must provide that Medicare entitlement causes a loss of coverage for Dependents.

10.7 Special Continuation of Coverage Period for Medicare Entitlement

When a covered Eligible Employee becomes entitled to Medicare and within 18 months experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

10.8 Early Termination Of COBRA Continuation Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, or the earlier of any of the following dates (if applicable):

(a) With respect to a COBRA Qualified Beneficiary entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the first day of the month that begins more than 30 days after the Social Security Administration makes a determination that the COBRA Qualified Beneficiary is no longer disabled.

(b) The date the COBRA Qualified Beneficiary becomes entitled to Medicare.

(c) The date the COBRA Qualified Beneficiary fails to make a required monthly payment within the 30 day grace period pursuant to this provision.

(d) The date the COBRA Qualified Beneficiary becomes covered under another employer group health plan (because of employment or otherwise) and that coverage

contains no exclusion or limitation with respect to any pre-existing condition.

(e) The date the COBRA Qualified Beneficiary becomes covered under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the HIPAA rules.

(f) The date the Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

10.9 Notification Of A Qualifying Event

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 the covered Eligible Employee's employment or reduction of hours of employment, his death, or his enrollment in Medicare (Part A, Part B, or both), an Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

A COBRA Qualified Beneficiary must notify the Plan Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the COBRA Qualified Beneficiary is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, in writing (describing the qualifying event and the date it occurred) to the Plan Administrator or designated COBRA administrator.

10.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, the coverage will be identical to the health coverage then being provided under the Plan to similarly situated Covered Individuals. COBRA Qualified Beneficiaries do not have to prove insurability to choose COBRA Continuation Coverage, but are required to pay for it.

10.11 Application And Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by a COBRA Qualified Beneficiary, as described in Section 10.9), the Plan Administrator will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to the Plan Administrator within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate. Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 45th day after he elected COBRA Continuation Coverage (or the 75th day following the start of an election period), and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Individuals. However, if a person qualifies for periods of extended coverage due to a disability

(whether his or another COBRA Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Individuals, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article XI, to the extent the terms of the Component Document are consistent with applicable law.

10.12 More Information

Each Covered Individual must keep the Plan Administrator informed of any changes in the addresses of family members. A copy of any notices sent to the Plan Administrator should be retained by the Covered Individual.

BENEFIT PROGRAM APPENDIX

(Updated effective January 1, 2018)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated in this Plan by reference.

Component Program	**Insured or Self-insured**	**Insurance Carrier or Administrator**
Medical	Self-insured	Anthem Blue Cross Blue Shield
Prescription Drug	Self-insured	Express Scripts
Wellness	Self-Insured	Interactive Health
Dental	Insured	Delta Dental
Vision	Insured	EyeMed
Long Term Disability	Insured	Prudential
Short Term Disability	Insured	Unum
Group Term Life	Insured	Prudential
Supplemental Term Life	Insured	Prudential
AD&D	Insured	Prudential
Employee Assistance Plan (EAP)	Self-insured	Mercy
Health FSA	Self-insured	Discovery Benefits

AFFILIATED EMPLOYER APPENDIX

(Updated effective January 1, 2018)

Affiliated Employers

Cole County; EIN: 43-1147326

PLAN SPONSOR ADOPTION PAGE

The undersigned, on behalf of Lutheran Senior Services hereby adopts Lutheran Senior Services Benefits, in the form attached hereto, effective as of January 1, 2018.

LUTHERAN SENIOR SERVICES

By: _____

Name: _____

Title: _____

Date: _____