Building Your Benefits Health & Welfare Plan

BASIC WRAP PLAN DOCUMENT

including as components:

Lithko Contracting, LLC Medical Plan
Lithko Contracting, LLC Dental Plan
Lithko Contracting, LLC Vision Plan
Lithko Contracting, LLC Group Life/AD&D Plan
Lithko Contracting, LLC Long-Term Disability Plan
Lithko Contracting, LLC Employee Assistance Program (EAP)
Lithko Contracting, LLC Health Flexible Spending Account (FSA)
Lithko Contracting, LLC Short-Term Disability (Self Insured) Plan

Originally Effective January 1, 2020
Amended and Restated Effective January 1, 2025

TABLE OF CONTENTS

ARTICLE I.
INTRODUCTION

1.1 **Establishment**. Lithko Contracting, LLC (hereinafter the "Employer") previously established, effective, January 1, 2020 the Building Your Benefits Health & Welfare Plan (the "Plan"). The Employer hereby amends and restates the Plan effective January 1, 2025**.**

It operates on a "Plan Year" running from January 1 through December 31. It is important to note that some Components of the Plan may operate on a different Plan Year than the ERISA Wrap Plan Year identified above.

1.2 **ERISA/Non-ERISA Entity.** Certain employers are subject to the Employee Retirement Income Security Act of 1974 ("ERISA") with respect to certain benefits provided to employees. In addition, certain benefits are not subject to ERISA regardless of the employer that sponsors them. ERISA imposes requirements on the way in which many types of benefits must be provided. Throughout this written document (including Exhibits A and B and all subsections thereof), language identified as applying to ERISA plans is only applicable to Employers subject to ERISA. Language identified as not applying to ERISA plans is only applicable to Employers that are not subject to ERISA. In general, Employers that are governmental entities, public schools, churches and some church related entities, and some Indian Tribe operations are not subject to ERISA. If the Employer is not subject to ERISA, the procedures described in this document are for illustrative purposes only. The existence of language describing ERISA terms and procedures for group health and welfare plans shall not make the Employer subject to ERISA regulation if the Employer otherwise meets the criteria for ERISA exemption.

It is the Employer's responsibility to determine whether it is subject to ERISA. Refer to Exhibit A for the ERISA/Non-ERISA status of the Employer, and refer to the section below for the ERISA/Non-ERISA status of each type of benefit offered under the Plan.

1.3 **Overall Plan Structure.** The Plan is a single employer welfare benefit plan within the meaning of Section 3(1) of the ERISA. The Plan provides a variety of Benefits. Those Benefits are provided through "components."

(a) **ERISA**. This Plan and the following component plans providing Benefits subject to ERISA are an employee welfare Benefit plan, within the meaning of Section 3(1) of ERISA and for purposes of ERISA:

- Lithko Contracting, LLC Medical Plan;
- Lithko Contracting, LLC Dental Plan;
- Lithko Contracting, LLC Vision Plan;
- Lithko Contracting, LLC Group Life/AD&D Plan;
- Lithko Contracting, LLC Long-Term Disability Plan;
- Lithko Contracting, LLC Employee Assistance Program (EAP);
- Lithko Contracting, LLC Health Flexible Spending Account (FSA);

(b) **Non-ERISA/Internal Revenue Code**. This Plan and the following component plans providing Benefits, while not subject to ERISA, are subject to Code provisions requiring a written plan document:

- Lithko Contracting, LLC Short-Term Disability (Self Insured) Plan;

To the extent a Benefit described in this Plan is not subject to ERISA, including the Benefit as part of this Plan is not intended, nor should it be construed as, to bring the

Benefit within ERISA. To the extent a Benefit described in this Plan is not subject to Section 125 of the Code, including the Benefit as part of this Plan is not intended, nor should it be construed as an attempt, to provide the Benefit through the cafeteria plan under Section 125 of the Code.

(c) **Multiple Purposes**. This Plan is intended to comply with the written plan document requirements of both ERISA and the Code. The official plan document for the Employer consists of (1) this written document, (2) the Employer specific information and design decisions reflected in Exhibit A and any attachment(s) or subsection(s) thereof, and (3) the Component Benefits described in Exhibit B and any attachment(s) or subsection(s) thereof. For Plans required to file Form 5500 report(s) with the Department of Labor (DOL) (generally, Plans with at least 100 Participants on a Component Benefit plan as of the beginning of the Plan Year), this written plan document shall act as a "wrap" plan document for the component benefits allowing them to be filed together on a single Form 5500 report.

1.4 **HIPAA**.

(a) **Privacy and Security Rules**. Portions of the Plan render the Plan a "covered entity" for purposes of the Privacy Rules and Security Rules as described in greater detail in Article XIV.

(b) **Portability**. Portions of the Plan are subject to the portability requirements of HIPAA, found at Part 7 of Title I of ERISA. Those portions shall be operated in compliance with those requirements.

ARTICLE II.
DEFINITIONS

The following words and phrases are used in the Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article. Some Definitions within this Article may not be used in the rest of the Articles of this Plan Document, depending upon the applicable Plan provisions.

2.1 **Accidental Death and Dismemberment Insurance Plan** means the Plan Component(s) that provides a benefit consisting of life insurance in case of the accidental death of the Covered Employee, or a portion of the benefit for the loss of a limb or the loss of use of specific body part(s) by the Covered Employee as a result of an accident.

2.2 **Adopting Employer** means an incorporated or unincorporated entity named in the Adoption Agreement that has more than one common law employee and acts as a Named Fiduciary for purposes of ERISA Section 402(a). Any successor entity that by merger, consolidation, purchase, or otherwise assumes the sponsorship and administration of the Plan becomes the Adopting Employer.

2.3 **Adoption Agreement** means the document executed by the Adopting Employer and Participating Employer(s), if applicable, through which the Employer adopts the Plan and thereby agrees to be bound by all terms and conditions of the Plan.

2.4 **Alternate Recipient** means any child of a Covered Employee in any Health Component who is recognized under a QMCSO as having a right to enrollment under the Plan with respect to the Covered Employee.

2.5 **Beneficiary** means the individual who is designated by the Covered Employee as the individual entitled to benefits provided under the applicable Life Insurance and/or Accidental Death and Dismemberment benefit(s) and who is designated in accordance with the procedures set forth in the respective Plan Component for which the Beneficiary is designated.

2.6 **Benefits** means the coverages made available under the Plan as described in the Exhibits.

2.7 **Business Travel Accident Insurance Plan** means the portion of the Plan through which life insurance is provided in case of the accidental death of the Covered Employee during business related travel, or a portion of the benefit for the loss of a limb or loss of use of specific body part(s) as a result of an accident during business related travel.

2.8 **Cafeteria Plan Regulations** means any final regulations, or proposed regulations upon which employers may rely, issued by the Department of Treasury under Section 125 of the Code.

2.9 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.10 **Contribution** means the amount(s) paid by the Employer of the Covered Employee to cover the cost of coverage under a Plan Component.

2.11 **Coverage Contract** means (1) any insurance contract secured from an insurance company licensed to do business in the state in which such contract is issued, or (2) any separate document, other than an insurance contract, describing a particular Benefit, which has been obtained for the purposes of providing Benefits under the Plan.

2.12 **Covered Individual** means a person, including a Participant, a dependent of a Participant, a spouse of a Participant, and any other person appropriately covered under a Benefit.

2.13 **Dental Coverage** means the group dental coverage made available by the Employer through a Coverage Contract that is attached to the Plan as an Exhibit and incorporated.

2.14 **Dependent Care Spending Account Plan** means the portion of the Plan through which certain dependent care expenses may be reimbursed in accordance with Section 129 of the Code.

2.15 **Effective Date** means the amended and restated date of this Plan, as identified in Exhibit A.

2.16 **Electronic Protected Health Information ("ePHI")** means PHI maintained or transmitted in electronic media including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.17 **Eligible Employee** means each Employee who has met the eligibility requirements as described in Section 3.1.

2.18 **Employee** means any person employed by the Employer, except that it shall not include:

(a) Any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan;

(b) Any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;

(c) Any leased employee (including, but not limited to, those individuals defined in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; or

(d) Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

2.19 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

2.20 **Employer** means Lithko Contracting, LLC or any U.S. affiliate or subsidiary that, with the consent of the Employer, also becomes an Employer by adopting the Plan or any successor business organization that assumes the obligations of the Employer. "Affiliate" means an entity (other than the Employer) which is part of a group of entities which includes the Employer and which constitutes (a) a controlled group of corporations (as defined in Section 414(b) of the Code), (b) in Section 414(c) of the Code), or (c) an affiliated service group (within the meaning of Section 414(m) of the Code).

2.21 **Exhibit** means an attachment to the Plan labeled "Exhibit", and any attachments or subsections thereof, the contents of which are incorporated by reference.

2.22 **Fiduciary** means a person who exercises any discretionary authority or control with respect to management of the Plan, or has any discretionary authority or responsibility regarding administration of the Plan, as defined in ERISA Section 3(21). The Employer and such other individuals either appointed by the Employer or deemed to be fiduciaries as a result of their actions shall serve as Fiduciaries under this Plan and fulfill the fiduciary responsibilities described in Part 4, Title I of ERISA including discharging their duties with respect to the Plan solely in the interest of the Covered Employee, Eligible Dependents, and Beneficiaries with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

2.23 **Flexible Benefits Plan or Flex Plan** means the portion of the Plan through which choices of Benefits and pre-tax payment thereof is made in accordance with Section 125 of the Code.

2.24 **Fund** means the Plan assets held by the Trustee (or Custodian, if applicable) for the exclusive benefit of Covered Employees and Eligible Dependents.

2.25 **Group Term Life Insurance Plan** means the portion of the Plan through which life insurance is provided.

2.26 **Health Care Reform** means the Patient Protection and Affordable Health Care Act, as amended by the Health Care and Education Reconciliation Act, and any regulatory guidance issued thereunder.

2.27 **Health Care Spending Account Plan** means the portion of the Plan through which certain medical expenses may be reimbursed in accordance with Section 105 of the Code.

2.28 **Health Reimbursement Account ("HRA") Plan** means the portion of the Plan through which certain medical expenses may be reimbursed in accordance with the employer-funded medical reimbursement program within the meaning of IRS Revenue Ruling 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

2.29 **Highly Compensated Participant** means Participants who are highly compensated as defined in Section 125(e)(1) of the Code.

2.30 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder, as amended from time to time.

2.31 **Insurer** means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, that is subject to state law regulating insurance, and that issues an Insurance Policy. "Insurer" also includes an HMO that is either a federally qualified HMO, an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as such an HMO and that issues an Insurance Policy.

2.32 **Key Employee** means Participants who are "Key Employees" as defined in Section 416(i) of the Code.

2.33 **Long Term Disability Insurance Plan** means the portion of the Plan through which long term disability insurance is provided to Covered Employees in the form of supplemental income during an extended period of time in which the Employee is unable to work as a result of illness, injury, or accident.

2.34 **Medical Coverage** means the group medical coverage made available by the Employer through one or more Coverage Contract(s) attached to the Plan as Part of an Exhibit and incorporated.

2.35 **Participant** means an Eligible Employee who participates in the Plan in accordance with Article III and has not ceased to be a Participant as described in Section 3.4.

2.36 **PHS Act** means the Public Health Service Act of 1944, as amended from time to time.

2.37 **Plan** means this written document, including Exhibits, Adoption Agreement, attachments and items incorporated by reference, which is intended to be the written plan document for purposes of ERISA and the Code.

2.38 **Plan Administrator** means the entity determined under Section 11.1, or its properly designated designee.

2.39 **Plan Sponsor** means the entity identified in Exhibit A.

2.40 **Plan Year** means the twelve-consecutive month period as is designated in Exhibit A. Notwithstanding the preceding, a Plan Year may be a period less than 12 months, if defined as such in the Exhibit.

2.41 **Privacy Rules** means the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.

2.42 **Protected Health Information ("PHI")** means protected health information as described in 45 C.F.R. § 160.103. PHI includes ePHI. PHI means protected health information that:

(a) is created or received by a covered entity (e.g., health plan, health care provider, or health care clearinghouse);
(b) relates to the past, present and future physical or mental health or condition of an individual; 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) either identifies the individual or reasonably could be used to identify the individual.

2.43 **Provider** means a third party service provider with whom the Employer and/or Plan Administrator has entered into a contract to assist in providing the Benefits pursuant to a Coverage Contract.

2.44 **Qualified Medical Child Support Order (QMCSO)** means a medical child support order that creates or recognizes the right of an Alternate Recipient to receive benefits for which a Covered Employee or beneficiary is eligible under a group health plan or assigns to an alternate recipient the right of a Covered Employee or beneficiary to receive benefits under a group health plan and is recognized by the group health plan as "qualified" because it includes information that meets other requirements of the QMCSO provisions. A properly completed National Medical Child Support Notice must be treated as a QMCSO.

2.45 **Rescission** or **Rescinded** means, to the extent required by Health Care Reform, a cancellation of coverage or discontinuance of coverage under a Benefit that has retroactive effect, other than a cancellation or discontinuance attributable to a failure to timely pay the cost of coverage.

2.46 **Security Incident** means "security incident" as defined in 45 C.F.R. Section 164.304, which generally defines "security incident" to include attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI.

2.47 **Security Rules** means the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C , as amended.

2.48 **Short Term Disability Insurance Plan** means the portion of the Plan through which short term disability coverage is provided to Covered Employees in the form of supplemental income for a limited period of time in which the Employee is unable to work as a result of illness, injury, or accident.

2.49 **Spouse** means an individual who is legally married to a Covered Employee. If elected by the Plan, Spouse shall include a Domestic Partner.

2.50 **Summary Health Information** means "summary health information" as defined in 45 C.F.R. Section 164.504, which generally defines "summary health information" to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving Benefits under the Plan from which certain identifiers have been deleted.

2.51 **Third-Party Administrator** means an entity appointed by the Plan Administrator for the administration of self-insured Plan Components.

2.52 **Vision Insurance Plan** means the group vision coverage made available by the Employer through a Coverage Contract attached to the Plan as an Exhibit and incorporated.

2.53 **Voluntary Accidental Death and Dismemberment Insurance Plan** means the portion of this Plan through which accident insurance is available on a voluntary basis.

2.54 **Wellness Program** means the Plan component that promotes healthy habits and disease prevention among Covered Employees and Eligible Dependents.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility Requirements**. An Employee shall be an Eligible Employee, able to participate in the Plan, upon meeting the eligibility requirements of any one of the applicable Benefits as described in the Exhibits. An Eligible Employee shall be entitled to enroll a dependent in a Benefit as provided in the applicable Coverage Contract.

3.2 **Notification of Participants**. The Plan Administrator shall give each Eligible Employee notice of the Employee's eligibility to participate in the Plan in sufficient time to enable such Eligible Employee to submit an application for participation in the Plan on or before the date on which the Eligible Employee would be able to begin participation.

3.3 **Application for Participation**. To become a Participant, an Eligible Employee may be required to execute and deliver to the Plan Administrator a signed request through the means necessary provided by the Plan Administrator in which the Eligible Employee applies to participate in the Plan and supplies any pertinent information that the Plan Administrator may reasonably require. In order to elect a specific component provided under the Plan, an Eligible Employee must elect that component on such forms and supply such information as the Plan Administrator may require and, if the cost of the component is not fully paid by the Employer, shall be required to share the cost of the component as provided in Article VI.

3.4 **Termination of Participation**. A Participant ceases participation in the Plan when he or she no longer participates, whether voluntarily or involuntarily, in any Benefit(s) provided through the Plan. Participation in a Benefit shall terminate as provided in the applicable Coverage Contract, provided that, regardless of the terms of the Coverage Contract, the Plan Administrator may terminate a Participant's participation in a Benefit if the Participant fails to make the full contribution required under Section 6.1 in a timely manner. Termination of participation in the Plan shall not prevent a former Participant from receiving continuation coverage, Benefits to which the former Participant became entitled while a Participant, or any coverage or Benefits specifically provided under a Coverage Contract.

Notwithstanding the foregoing, and unless expressly provided to the contrary in a Coverage Contract, coverage of any Covered Individual under a Benefit may be terminated where the Plan Administrator determines that the person is ineligible for coverage; that enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a misrepresentation pertaining to such person; that the person failed to supply information reasonably requested by the Plan Administrator; that the person failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the person (or any other person who acts or fails to act on behalf of the person). Where a dependent is disenrolled due to such conduct, the Plan Administrator may in its discretion disenroll the Employee and/or one or more of the Employee's other dependents where it appears such person(s) were complicit in the misrepresentation. Where an Employee is disenrolled due to such conduct, 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 person's enrollment or, if later, the date the person became ineligible; provided, however, that to the extent the Benefit is subject to Health Care Reform, the Rescission will be made only in the circumstances allowed under Health Care Reform and in

accordance with this Section 3.4. A Covered Individual whose coverage is being Rescinded will be provided a thirty (30) day notice of the Rescission to the extent required by and as described under Health Care Reform. At the conclusion of the thirty (30) day notice period (if applicable), coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under Section 14.7.

3.5 **Conditions of Participation**. As a condition of participation and receipt of Benefits under the Plan, the Participant agrees to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Plan Administrator with respect to any provider of services involved in a claim under the Plan;

(c) Submit to the Plan Administrator all notifications, reports, bills, and other information that the Plan Administrator may reasonably require;

(d) Agree to repay any overpayments or incorrect payments received through the Plan; and

(e) Agree to provide required proof or documentation regarding eligibility upon written request within a reasonable period of time.

Failure to comply with these conditions relieves the Plan, Plan Administrator and Employer from any and all obligations under the Plan.

ARTICLE IV.
INSURED BENEFITS

4.1 **Benefits Paid Through Insurance Contracts**. The Employer shall acquire the necessary insurance contracts to provide the insured Benefits under the Plan. Such Benefits under the Plan shall be paid entirely through and in accordance with the insurance contracts acquired to provide such Benefits including, but not limited to, claims procedures and appeal rights contained therein. A more complete description of the Benefits may be found in such insurance contracts, which are hereby incorporated by reference and further described in Exhibit B. The Employer, in its discretion, may from time to time amend or revise the Benefits provided by the Plan and described in the attached Exhibit B in which case a substituted exhibit shall be attached to the Plan and become a part hereof. There shall be no liability of any kind on the part of an Employer to make payments or otherwise provide Benefits under this portion of Plan.

4.2 **Termination of Benefit**. Any Benefit provided under an insurance contract purchased or entered into pursuant to the Plan shall terminate as provided in such insurance contract.

4.3 **Sole Source of Benefits**. With respect to insured Benefits, no Covered Individual or beneficiary thereof shall have any right to, or interest in, any assets of the Employer regarding insured Benefits under the Plan. The sole source of Benefits under this portion of the Plan is the insurance contracts acquired to provide such Benefits.

4.4 **Coordination**. Entitlement to Benefits under a particular insurance contract does not necessarily guarantee entitlement to Benefits under any other Coverage Contract or Employer-sponsored program.

4.5 **Continuation of Coverage**. To the extent federal law requires continuation of coverage, such requirements shall be satisfied. There shall also be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state laws are not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the insurance contracts through which Benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

4.6 **Nondiscrimination Requirements**. This Plan, with respect to each Benefit, shall comply with the applicable nondiscrimination requirements (if any) under the Code, and/or Section 2716 of the Public Health Services Act.

ARTICLE V.
SELF-INSURED (NOT INSURED) BENEFITS

5.1 **Benefits Not Paid Through Insurance Contracts**. The Plan Administrator shall obtain the necessary Coverage Contracts to provide Benefits under the Plan that are not insured. Such Benefits shall be paid through and in accordance with such Coverage Contracts including, but not limited to, claims procedures and appeal rights contained therein. A more complete description of the Benefits may be found in such Coverage Contracts, which are hereby incorporated by reference and further described in Exhibit B. The Plan Administrator, in its discretion, may from time to time amend or revise the Benefits provided by the Plan and described in the attached Exhibit B in which case a substituted exhibit shall be attached to the Plan and become a part hereof.

5.2 **Termination of Benefit**. Any Benefit provided under a Coverage Contract shall terminate as provided in such Coverage Contract.

5.3 **Sole Source of Benefits**. The sole source of Benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trust identified in Exhibit A. No Benefits are paid through insurance contracts.

5.4 **Coordination**. Entitlement to Benefits under a particular Coverage Contract does not necessarily guarantee entitlement to Benefits under any other Coverage Contract or Employer-sponsored program.

5.5 **Continuation of Coverage**. To the extent federal law requires continuation of coverage, such requirements shall be satisfied. In addition, any continuation and conversion rights provided under the terms of the insurance contracts through which Benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

5.6 **Nondiscrimination Requirements**. This Plan, with respect to each Benefit, shall comply with the applicable nondiscrimination requirements under the Code.

ARTICLE VI.
FUNDING

6.1 **Employee Contributions**. The Employer may require the Participant to make contributions to the Plan as a condition of participation. Such contributions shall be made on a periodic basis and are generally due by the first day of each month unless the Employer has agreed to another payment schedule. After-tax contributions may be made pursuant to a salary deduction agreement under which contributions are deducted from salary after tax withholdings have been made. Alternatively, the Employer may permit amounts for which the Participant is responsible to contribute be funded on a pre-tax basis through a cafeteria plan within the meaning of Section 125 of the Code. Nothing in such cafeteria plan shall be construed as amending or in any other way influencing the administration of the Plan. A contribution grace period will be provided if one is required under applicable law or one is needed to ensure an offer of coverage has been made in accordance with Treas. Reg. § 54.4980H-3(g).

6.2 **Employer Contributions**. The Plan Administrator shall determine, on a periodic basis, the cost to operate the Plan including, but not limited to, claims costs, premium costs, reasonable administrative expenses, and adequate reserves. Such costs, to the extent not funded with Employee contributions, shall be allocated by the Plan Administrator to the Employer.

6.3 **Operating Expenses for this Plan**. Operating expenses shall be paid from Plan assets or the general assets of the Employer.

6.4 **Plan Assets**. Plan assets shall be used for the sole and exclusive purpose of providing benefits under the Plan and defraying reasonable administrative costs of the Plan (including disposition of Plan assets upon termination of the Plan).

6.5 **Trust**. Except as otherwise required by law, nothing herein will be construed to require the Employer or Plan Administrator to establish a trust, maintain any fund, or segregate any assets for the benefit of any Covered Employee, Eligible Dependent, Beneficiary, or any other person, and none of them shall have any claims against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

Notwithstanding the foregoing, the Employer may, at its sole discretion or as required by law, establish a Trust for the purpose of paying benefits under any Plan Component. All payments of benefits under a Plan Component funded through a Trust shall be made out of the Trust. Assets held in Trust may be used to pay the Plan's administrative expenses.

If the Employer establishes a Trust for one or more Plan Components, the Plan assets corresponding to those Plan Components will be held by the Trustee(s) pursuant to an Agreement executed by the Employer and the Trustee. Assets held by the Trustee will not be earmarked on behalf of any Covered Employee, Eligible Dependent, or Beneficiary.

6.6 **Insurance Company Refunds and Rebates.** If an Insurer, health maintenance organization, pharmacy benefit manager or other party pays any refund, rebate (including any medical loss ratio rebate pursuant to Health Care Reform, allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Benefit (a "Recovery"), whether such Recovery be paid in cash or effected 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, but instead 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 Employees (or dependents) for coverage under the Plan and will not

otherwise be shared with Employees (or dependents). If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law. The portion of a Recovery treated as an asset of the Plan will be (a) used solely for the benefit of the Participants participating in the component with respect to which the Recovery was provided, and (b) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund of Participant premiums, a premium holiday, an increase in benefits, etc.), as determined by the Plan Administrator in its sole discretion. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such Recovery.

ARTICLE VII.
GENERAL RULES FOR CLAIMS AND APPEAL PROCEDURES

7.1 **Purpose**. To the extent a Coverage Contract does not contain a claims and claims appeal procedure compliant with ERISA, this Article VII, Article VIII [Claims and Appeal Procedures for Group Health Plans], Article IX [Claims and Appeal Procedures for Disability Benefits], and Article X [Claims and Appeal Procedures for Other Benefits] shall apply with respect to the Benefits provided under the Plan. The provisions of this Article VII that are required by Health Care Reform shall be effective as of the date required by Health Care Reform or such later date as of which the Department of Labor begins enforcing such requirements.

7.2 **Claim Submission**. A claim for Benefits must be made in writing and submitted to the Plan.

Note: Claims and appeals for Benefits provided through an insurance contract are handled directly by the Insurer.

7.3 **Definitions**. The following definitions shall apply for purposes of Articles VII – X only:

(a) **Adverse Benefit Determination** means a denial, reduction, or termination of a Benefit, a failure to provide or make payment (in whole or in part) for a Benefit, or a Rescission.

(b) **Authorized Representative** means a person designated by a Claimant or the Plan to act on behalf of a Claimant with respect to a Benefit claim or appeal. An assignment for purposes of payment is ***not*** designation of an "Authorized Representative."

(c) **Claimant** means a person who believes he/she is entitled to Benefits under the Plan. The term Claimant shall also include a Claimant's Authorized Representative, if applicable.

(d) **Concurrent Care Claim** means a claim with prior authorization that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claims:(i) where the reconsideration results in a reduction or termination of coverage for a previously approved course of treatment, and (ii) where an extension is requested by the Claimant for coverage beyond the initially approved course of treatment.

(e) **External Review** means, to the extent required by and in accordance with Health Care Reform, an independent review of an Adverse Benefit Determination (following final appeal under the Plan) under applicable state or federal external review procedures.

(f) **Post-Service Claim** means any claim for a Benefit under the Plan that is submitted for payment or reimbursement after the services have been rendered.

(g) **Pre-Service Claim** means any claim for a Benefit under the Plan where receipt of the Benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care.

(h) **Urgent Pre-Service Claim** means a specific type of Pre-Service Claim under the Plan. An Urgent Pre-Service Claim is any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations: (i) could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (ii) 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.

If a physician with knowledge of the Claimant's medical condition determines that a claim is an Urgent Pre-Service Claim, the claim will be treated as an Urgent Pre-Service Claim. A physician may be required to complete an "Urgent Pre-Service Claim Determination by Physician" form, if requested, in such cases.

7.4 **Types of Claims**.

(a) There are four categories of claims as defined above:

(1) Concurrent Care Claim;

(2) Post-Service Claim;

(3) Pre-Service Claim; and

(4) Urgent Pre-Service Claim.

(b) Each category of claim has its own set of claim and appeal requirements. The primary difference between the categories of claims is the timeframe within which claims will be determined.

(c) For the purpose of determining which claim and appeal procedures to follow, the claim type is determined initially. However, if the nature of the claim changes as it proceeds through the claim and appeal process, the claim can be re-characterized. For example, a claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim. Once the services are rendered and submitted to the Plan for payment, it becomes a Post-Service Claim.

7.5 **Authorized Representative**. For purposes of the claims and appeal procedures an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a claim or appeal.

For Pre-Service Claims, Urgent Pre-Service Claims, and Concurrent Care Claims, the Plan will recognize a healthcare provider with knowledge of the Claimant's medical condition (e.g., the treating physician) as the Claimant's Authorized Representative for both claims and appeals, unless the Claimant provides specific written direction otherwise.

For Post-Service Claims and Claims under Articles IX and X, in order for the Plan to recognize a person as an Authorized Representative, written notification to that affect, signed by the Claimant and notarized, must be received by the Plan Administrator.

Once an Authorized Representative is recognized, the Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless the Claimant provides specific written direction otherwise.

7.6 **Access to Relevant Documents**. In order (1) to evaluate whether to request review of an Adverse Benefit Determination, and (2) if review is requested, to prepare for such review, the Claimant or the Claimant's Authorized Representative will have access to all relevant documents. A document, record or other information is "relevant" if it was relied upon in making the determination, or was submitted to the Plan, considered by the Plan, or generated in the course

of making the Benefit determination without regard to whether it was relied upon in making the Benefit determination.

7.7 **Questions Regarding Claims and Appeals Procedures**. If a Claimant has any questions regarding these procedures, the Claimant should contact the Plan Administrator.

7.8 **Conflicts of Interest**. All claims and appeals will be adjudicated in a manner so that the independence and impartiality of the persons involved in making the determination are ensured. Decisions regarding hiring, compensation, termination, and similar matters with respect to any person involved in the determination (e.g., a claims adjudicator or medical expert) shall not be based upon the likelihood that the person will support a denial of benefits.

7.9 **Legal Action**. If a Claimant intends to initiate legal action, including legal action under Section 502(a) of ERISA, he or she must do so within two (2) years after receipt of a notification of an Adverse Benefit Determination at the final level of appeal, unless a different time period is provided in the Coverage Contract applicable to the Benefit with respect to which the action is being brought. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined below, legal action must be brought within two (2) years of the date the Claimant's claim for benefits was submitted to this Plan, unless a different time period is provided in the Coverage Contract applicable to the Benefit with respect to which the action is being brought. Claimants may not bring legal action after the expiration of the applicable limitations period. With respect to Benefits subject to Health Care Reform, this provision applies to the fullest extent consistent with applicable Health Care Reform requirements.

ARTICLE VIII.
CLAIMS AND APPEAL PROCEDURES FOR GROUP HEALTH PLANS

8.1 **Purpose**. This Article VIII shall generally apply with respect to the Benefits provided under a component of the Plan that constitutes a group health plan for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such component does not contain a claims and claims appeal procedure compliant with ERISA including, if applicable, Health Care Reform. However, if a claim for Benefits constitutes a claim for disability benefits, such claim shall be subject to Article IX. The provisions of this Article VIII that are required by Health Care Reform shall be effective as of the date required by Health Care Reform or such later date as of which the Department of Labor begins enforcing such requirements.

8.2 **Timeframes for Claim Decisions**. A Claimant may voluntarily agree to extend the timeframes specified below for the Plan to make a decision.

(a) **Timeframes**. The following timeframes apply unless the claim is incomplete, as described below.

(1) **Post-Service Claims**. The Plan will determine the claim within a reasonable period of time not to exceed thirty (30) days from receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial thirty (30) day time period for determining the claim.

(2) **Pre-Service Claims**. The Plan will determine the claim within a reasonable period of time not to exceed fifteen (15) days from receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial fifteen (15) day time period for determining the claim.

(3) **Urgent Pre-Service Claims**. The Plan will determine the claim as soon as possible taking into account medical exigencies, but no later than seventy-two (72) hours after receipt of the claim by the Plan.

(4) **Concurrent Care Claims**.

(i) For a reduction or termination of coverage for a previously approved ongoing course of treatment, the Plan will make the determination sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved course of treatment is reduced or terminated.

(ii) Where an extension is requested by the Claimant for coverage beyond the initially approved course of treatment, and

a. If the request meets the definition of an Urgent Pre-Service Claim and is filed at least twenty-four (24) hours prior to the end

of the course of treatment, the Plan will determine the claim as soon as possible, but no later twenty-four (24) hours after receipt of the request.

b. If the request meets the definition of an Urgent Pre-Service Claim and is filed less than twenty-four (24) hours prior to the end of the course of treatment, the Plan will determine the claim as soon as possible, but no later than seventy-two (72) hours after receipt of the request.

c. If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will determine the claim within a reasonable period of time not to exceed fifteen (15) days from receipt of the request. If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the claim.

(b) **Incorrectly Filed and Incomplete Claims**.

(1) **Incorrectly Filed Pre-Service Claims and Urgent Pre-Service Claims**. If there is a communication by a Claimant that (i) is received by a person or organizational unit customarily responsible for handling benefit matters for the Employer, (ii) names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, and (iii) fails to follow the Plan's procedures for filing a Pre-Service Claim or an Urgent Pre-Service Claim, the Plan will notify the Claimant and explain the proper procedures as soon as possible, but no later than five (5) days from receipt of the communication regarding a Pre-Service Claim and no later than twenty-four (24) hours from receipt of the communication regarding an Urgent Pre-Service Claim. Notification may be made orally to the Claimant unless the Claimant requests written notice.

(2) **Incomplete Post-Service Claims and Pre-Service Claims** (not including Urgent Pre-Service Claims). Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, the Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

The notification will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, the Plan will decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be denied.

(3) **Incomplete Urgent Pre-Service Claims**. The Plan will notify the Claimant of an incomplete claim as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim. The notification will describe the information necessary to complete the claim and specify the timeframe of at

least forty-eight (48) hours within which the claim must be complete. Notification may be made orally to the Claimant unless the Claimant requests written notice.

The Plan will make a claim determination as soon as possible but not later than the earlier of (i) forty-eight (48) hours after receipt of the specified information, or (ii) the end of the period of time provided to submit the specified information.

8.3 **Notification of Claim Decisions**.

(a) **Timeframe and Notification of a Claim Determination**.

(1) Notification will be provided within the time frames contained in Section 8.2(a) only if the decision is an Adverse Benefit Determination for Post-Service Claims and Concurrent Care Claims.

(2) Notification will be provided within the time frames contained in Section 8.2(a) whether the claim or request is approved or denied for Pre-Service Claims (including Urgent Pre-Service Claims).

(b) **Content of Notification**.

(1) **Adverse Benefit Determination**. Notice of an Adverse Benefit Determination will be provided in written or electronic form. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than three (3) days after the oral notification. The notice will be provided in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2590.715-2719, to the extent such regulations are applicable to the Benefit.

The notification will include the following:

(i) Information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, the claim amount, and, to the extent required under Health Care Reform, a statement of the availability, upon request, of the diagnosis and treatment codes (if any) and their corresponding meanings;

(ii) The specific reason(s) for the determination, including the denial code (if any) and its corresponding meaning;

(iii) A description of the Plan's standard, if any, used to make the determination;

(iv) Reference to the specific Plan provision(s) on which the determination is based;

(v) A description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;

(vi) A description of the internal appeals and external review processes (if any) available under the Plan, including how to initiate an appeal and the

procedures and time limits applicable to an appeal, and (if applicable) the right to bring suit under ERISA Section 502(a) after an appeal;

(vii) Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information was relied upon in making the Adverse Benefit Determination, which will be provided free of charge upon request;

(viii) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

(ix) To the extent required under Health Care Reform, disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes (if any).

(2) **Not Adverse Decision**. For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for prior authorization has been approved will be provided.

8.4 **Appeals Process**. The following will apply to all types of Adverse Benefit Determinations:

(a) **Right to Review Claim File**. The Claimant will have the right to review his or her claim file.

(b) **Submission and Consideration of Comments**. To the extent required under Health Care Reform, the Claimant will have the right to present "evidence and testimony" to the extent required by, and in accordance with, Health Care Reform. Regardless of whether Health Care Reform requires the right to present "evidence and testimony," the Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

(c) **Disclosure of New or Additional Evidence**. The Claimant will be provided, without charge and as soon as possible, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan, to the extent required by, and in accordance with, Health Care Reform.

(d) **Disclosure of New or Additional Rationale**. The Claimant will be provided, without charge and as soon as possible, any new or additional rationale for the Adverse Benefit Determination, to the extent required by, and in accordance with, Health Care Reform.

(e) **Decision**. The review will be made by a named fiduciary and a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.

(f) **Consultation with Independent Medical Expert**. In the case of a claim denied on the grounds of a medical judgment, a healthcare provider with appropriate training and experience will be consulted. The healthcare provider who is consulted on appeal will not

be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

8.5 **Filing an Appeal**. If there is an Adverse Benefit Determination, the Claimant may request a review by the Plan by filing an appeal.

(a) An appeal request must be in writing and submitted to the Plan, except for expedited reviews of Urgent Pre-Service Claims under the Plan. A Claimant may request such an expedited review orally or in writing and all necessary information (including the Plan's determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

(b) An appeal must include the following information:

(1) The name of the Plan;

(2) The identity of the Claimant, including name, address, and date of birth;

(3) Information regarding the claim request being appealed, such as:

(i) for Post-Service Claims, a copy of the Explanation of Benefits or the claim number listed on the Explanation of Benefits; and

(ii) for other types of claims, a copy of the Adverse Benefit Determination notice that the Claimant received, or other information to identify the claim;

(4) A statement that the Claimant is requesting an appeal;

(5) An explanation of why an appeal is being requested, including the particular aspect of the Adverse Benefit Determination the Claimant is disputing; and

(6) Supporting documentation.

(c) An appeal of an Adverse Benefit Determination must be submitted to the Plan within one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination of a claim. If an appeal is not requested within this one hundred and eighty (180) day time period, the Claimant loses the right to appeal.

8.6 **Timeframes for Appeal Determinations**. A Claimant may voluntarily agree to extend the timeframes specified below to make a decision.

(a) **Post-Service Claims**. The Plan will make a determination within a reasonable period of time not to exceed sixty (60) days from the date the appeal was received.

(b) **Pre-Service Claims**. The Plan will make a determination within a reasonable period of time not to exceed thirty (30) days from the date the appeal was received.

(c) **Urgent Pre-Service Claims**. The Plan will make a determination as soon as possible, but no later than seventy-two (72) hours from the date the appeal was received.

(d) **Concurrent Care Claims**.

(1) For an appeal of a reduction or termination of coverage for a previously approved ongoing course of treatment, the Plan will make a determination before the course of treatment is reduced or terminated.

(2) Where an extension is requested by the Claimant for coverage beyond the initially approved Benefit, and

(i) If the request meets the definition of an Urgent Pre-Service Claim, the Plan will make a determination as soon as possible, but no later than seventy-two (72) hours from the date the appeal was received.

(ii) If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will make a determination within a reasonable period of time not to exceed thirty (30) days from the date the appeal was received.

8.7 **Notification of Appeal Decisions**.

(a) **Timeframe and Notification**. Written or electronic notification of the Plan's determination will be provided to the Claimant for all appeals within the time frames contained in Section 8.6. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2590.715-2719, to the extent such regulations are applicable to the Benefit.

(b) **Content of Notification**.

(1) **Adverse Benefit Determination**. The notification will include the following:

(i) Information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, the claim amount, and, to the extent required under Health Care Reform, a statement of the availability, upon request, of the diagnosis and treatment codes (if any) and their corresponding meanings;

(ii) A discussion of the Adverse Benefit Determination, including the specific reason(s) for the determination, the denial code (if any) and its corresponding meaning, and the Plan's standard, if any, used to make the determination;

(iii) Reference to the specific Plan provision(s) on which the determination is based;

(iv) A description of the External Review process (if any) available under the Plan;

(v) A statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for Benefits;

(vi) A statement regarding additional levels of appeal (if any) and the right to sue in federal court;

(vii) Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information will be provided free of charge upon request;

(viii) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

(ix) A disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the external review process (if any).

(2) **Not Adverse Decision**. Notice will be provided informing the Claimant that the decision has been reversed and the claim has been approved or, under the Plan, a Pre-Service Claim has been approved.

8.8 **External Review**. Health Care Reform requires External Review be made available in certain circumstances under applicable state or federal procedures. In addition, Health Care Reform requires an expedited External Review be made available under certain circumstances. The Plan will provide External Review, including expedited External Review, to the extent required by, and in accordance with, Health Care Reform. External Review decisions are binding on the Plan and Claimant except to the extent other remedies are available under applicable state and/or federal law.

ARTICLE IX.
CLAIMS AND APPEAL PROCEDURES FOR DISABILITY BENEFITS

9.1 **Purpose**. This Article IX shall apply with respect to the Benefits, regardless of the component of the Plan under which they are provided, that constitute disability benefits for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such Benefits does not contain a claims and claims appeal procedure compliant with ERISA. Accordingly, this Article IX may apply to claims for Benefits under the disability component(s) of the Plan (if any) and under any other component of this Plan where the claim is a claim for disability benefits under the Plan.

9.2 **Compliance with Applicable Law**. Notwithstanding anything herein to the contrary, in the event the Department of Labor implements new regulations regarding disability benefit claims and appeals that require procedures that differ from the procedures described in this Article IX, the Plan shall follow the procedures required by such regulations on and after the date on which they become applicable to the Plan.

9.3 **Benefit Determination and Denial**.

(a) The Plan shall notify a Claimant within a reasonable period of time not to exceed forty-five (45) days after receipt of a written claim for Benefits of the Claimant's eligibility, or non-eligibility, for Benefits under the Plan. If it is determined that a person is not eligible for Benefits, or for full Benefits, the notice shall set forth as follows:

(1) The specific reason(s) for the determination;

(2) Reference to the specific Plan provision(s) on which the determination is based;

(3) A description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;

(4) A description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to bring suit under ERISA § 502(a) after an appeal;

(5) Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information was relied upon in making the Adverse Benefit Determination, which will be provided free of charge upon request; and

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.

(b) If the Plan determines that there are matters beyond the control of the Plan requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which a decision is expected to be made, and may extend the time for up to two (2) additional thirty (30) day periods. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, the Plan's period of time to make a decision is "tolled." Tolling means the period of time in which the Plan must determine a claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds. For this purpose, notification can be made orally to the Claimant or the health

care professional, unless the Claimant requests written notice. The notification will include a time frame in which the necessary information must be provided (which shall be at least forty-five (45) day in duration). Once the necessary information has been provided, the Plan must decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be decided without that information.

9.4 **Appeal Process**.

(a) If a Claimant is determined by the Plan not to be eligible for Benefits, or if the Claimant believes that he or she is entitled to greater or different Benefits, the Claimant shall have the opportunity to have the claim reviewed by the Plan by filing a petition for review within one hundred eighty (180) days after receipt by the Claimant of the notice issued by the Plan. That petition shall state the specific reason(s) the Claimant believes he or she is entitled to Benefits, or greater or different Benefits. Within a reasonable period of time not to exceed forty-five (45) days after receipt of that petition, the Plan shall afford the Claimant (and the Claimant's counsel, if any) an opportunity to present the Claimant's position to the Plan orally or in writing, and the Claimant (or the Claimant's counsel) shall have the right to review the pertinent documents. The Plan shall notify the Claimant of its decision in writing within said forty-five (45) day period, stating specifically the basis of said decision, written in a manner calculated to be understood by the Claimant, and the specific provisions of the Plan on which the decision is based. In the event of the death of a Claimant, the same procedure shall be applicable to the Claimant's beneficiaries.

For adverse appeal determinations, the notification shall reflect at least the following:

(1) The specific reason(s) for the Adverse Benefit Determination;

(2) Reference to the specific Plan provision(s) on which the determination is based;

(3) A statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant’s claim for Benefits;

(4) A statement regarding additional levels of appeal (if any) and the right to bring suit under ERISA § 502(a);

(5) Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information will be provided free of charge upon request; and

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant’s circumstances, or a statement that such explanation will be provided free of charge upon request.

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which

a decision is expected to be made, and may extend the time for up to forty-five (45) days.

ARTICLE X.
CLAIMS AND APPEAL PROCEDURES FOR OTHER BENEFITS

10.1 **Purpose**. This Article X shall apply with respect to the Benefits that (1) are provided under a component of the Plan that is subject to ERISA, (2) are provided under a component of the Plan that does not constitute a group health plan for purposes of 29 C.F.R. § 2560.503-1, and (3) do not constitute disability benefits for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such Benefits does not contain a claims and claims appeal procedure compliant with ERISA.

10.2 **Benefit Determination and Denial**.

(a) The Plan shall notify a Claimant within a reasonable period of time not to exceed ninety (90) days after receipt of a written claim for Benefits of the Claimant's eligibility, or non-eligibility, for Benefits under the Plan. If it is determined that a person is not eligible for Benefits, or for full Benefits, the notice shall set forth as follows:

(1) The specific reason(s) for the determination;

(2) Reference to the specific Plan provision(s) on which the determination is based;

(3) A description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary; and

(4) A description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to bring suit under ERISA § 502(a) after an appeal.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional ninety (90) days.

10.3 **Appeal Process**.

(a) If a Claimant is determined by the Plan not to be eligible for Benefits, or if the Claimant believes that he or she is entitled to greater or different Benefits, the Claimant shall have the opportunity to have the claim reviewed by the Plan by filing a petition for review within sixty (60) days after receipt by the Claimant of the notice issued by the Plan. That petition shall state the specific reasons the Claimant believes he or she is entitled to Benefits or greater or different Benefits. Within a reasonable period of time not to exceed sixty (60) days after receipt of that petition, the Plan shall afford the Claimant (and the Claimant's counsel, if any) an opportunity to present the Claimant's position to the Plan orally or in writing, and the Claimant (or the Claimant's counsel) shall have the right to review the pertinent documents. The Plan shall notify the Claimant of its decision in writing within said sixty (60) day period, stating specifically the basis of said decision written in a manner calculated to be understood by the Claimant and the specific provisions of the Plan on which the decision is based. In the event of the death of a Claimant, the same procedure shall be applicable to the Claimant's beneficiaries.

For adverse appeal determinations, the notification shall reflect at least the following:

(1) The specific reason(s) for the Adverse Benefit Determination;

(2) Reference to the specific Plan provision(s) on which the determination is based;

(3) A statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for Benefits; and

(4) A statement regarding additional levels of appeal (if any) and the right to bring suit under ERISA § 502(a).

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which a decision is expected to be made, and may extend the time for up to sixty (60) days.

ARTICLE XI.
ADMINISTRATION

11.1 **Plan Administrator**.

(a) The Plan Administrator shall be responsible for compliance with the statutory responsibilities including, but not limited to, ERISA. The Plan Administrator shall also be responsible for, directly or indirectly, the day to day operations of the Plan, including each Benefit offered hereunder. The Plan Administrator shall be the named fiduciary of the Plan in accordance with Section 402 of ERISA and, therefore, shall have the discretionary authority to control and manage the operation and administration of the Plan including, but not limited to, the interpretation and application of the terms of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

(b) The Employer shall be the Plan Administrator unless its managing body designates a person or persons other than the Employer to be the Plan Administrator. The Employer shall also be the Plan Administrator if the person or persons so designated for any reason cease to be the Plan Administrator.

(c) The Plan Administrator may designate individuals or entities to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of the Plan. Where Benefits under the Plan are provided through an Insurer, that entity shall be the claims administrator with respect to those Benefits. In all other situations, the Plan Administrator shall be the claims administrator unless the Plan Administrator contracts with another entity to act on its behalf.

11.2 **Agent for Service of Legal Process**. The agent for service of legal process for the Plan is identified in the Exhibit A. Legal process may also be served on the Plan Administrator or, if applicable, the Trustee(s).

11.3 **Allocation of Responsibility for Administration**. The Plan Administrator shall have the sole responsibility for the administration of the Plan as is specifically described in the Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under the Plan including the Coverage Contract(s). The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under the Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under the Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in the Plan.

11.4 **Rules and Decisions**. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, and/or legal counsel.

11.5 **Electronic Forms**. Notwithstanding anything in the Plan to the contrary, including any documentation incorporated by reference, any required forms may, at the Plan Administrator's

discretion, be required or permitted to be sent and/or made by electronic means, to the extent not prohibited by applicable law. For this purpose, "forms" includes, but is not limited to, participation agreements, elections, notifications/notices, applications, etc.

11.6 **Procedures**. The Plan Administrator may act at a meeting or in writing. The Plan Administrator may adopt such by-laws and regulations as it deems desirable for the conduct of the Plan's affairs and as are consistent with the terms of the Plan.

11.7 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

11.8 **Other Powers and Duties of the Plan Administrator**. The Plan Administrator, or its designee, shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) Discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, except to the extent the eligibility determinations are governed by a Coverage Contract, and to determine all questions arising in the administration and application of the Plan, except to the extent such eligibility determinations are governed by a Coverage Contract;

(b) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) To appoint individuals to assist in the administration of the Plan and any other agents he or she deems advisable including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any Benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a Benefit under the Plan.

11.9 **Plan Interpretation**. The Plan will be administered in accordance with its terms. The Plan Administrator and/or any other fiduciary acting as a fiduciary with respect to the Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate the Plan, to make factual findings, to construe the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on the Plan, Covered Individuals, and all interested parties.

11.10 **Indemnification**. To the maximum extent allowed by, and in accordance with, applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.

11.11 **Changes by the Plan Administrator**. If the Plan Administrator determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such

requirements or limitation. Such action may include, without limitation, a modification of elections made by a Highly Compensated Participant or Key Employee and a re-characterization within the Plan Year of Benefits provided under the Plan as taxable income with or without consent of such Employee.

ARTICLE XII.
RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

12.1 **Applicability.** The provisions of this Article XII apply to the extent the reimbursement and subrogation terms of an applicable Coverage Contract do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Coverage Contract supply greater rights, the terms of such Coverage Contract will apply. For purposes of this Article, a Coverage Contract is "applicable" if benefits under the Coverage Contract are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article, a law will not be considered an "applicable law" if it is preempted by ERISA.

12.2 **Corrective Payments.** To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans (as defined under Section 12.9), this Plan will have the right to pay any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

12.3 **Reimbursement.** To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person (as defined under Section 12.9) exceed the maximum amount necessary to satisfy the intent of this provision or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion will determine:

(a) The Covered Person;

(b) If the Covered Person is an eligible dependent or former eligible dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible dependent;

(c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;

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

(e) Any other organizations.

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

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or

the provider, or both. This same rule applies if the Plan makes payment to a Covered Person 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 Person 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 Person (or anyone who received such payment on behalf of the Covered Person), from the payment made by the Other Plan or Covered 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 Covered 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 Person'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 Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person'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 Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). 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 Person for an injury or sickness for which an Other Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, will be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the 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 Person 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 Person, 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.

12.4 **Subrogation.** To the extent permitted by applicable law, the Plan will be subrogated, to the extent of benefits paid or payable by this Plan, 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 Person 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 Person in connection with any efforts to recover monies from any Other Plan, 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 Person, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

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

This Plan will also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person 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 Person, 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 Person'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 Person as soon as administratively practical. The Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

12.5 **Implementation.** The Plan Administrator will determine which of the Plan's rights and remedies it is within 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, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

12.6 **Subrogation/Reimbursement Agreement.** To the extent permitted by applicable law, except as otherwise provided herein (e.g., the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person 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 such benefits payments to the extent that the Covered Person 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 Person whole. This reimbursement must be made within 30 days after the Covered Person (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 Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan will be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Section 12.6 will be construed to prevent application of the provisions of Section 12.3 regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

12.7 **Constructive Trust.** In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan will have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust will be imposed upon the person or entity then in possession of such compensation.

12.8 **Right to Receive and Release Necessary Information.** For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision**.**

12.9 **Special Definitions.** For purposes of this Article XII, the following special definitions will apply:

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

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

1. Any group, blanket or franchise health insurance, or coverage similar to same;
2. A group contractual prepayment or indemnity Plan, or coverage similar to same;
3. A Health Maintenance Organization (HMO), whether group practice or individual practice association;
4. A labor-management trusted Plan or a union welfare Plan;
5. An Employer or multiemployer Plan or Employee welfare benefit Plan;
6. A governmental medical benefit program;
7. Insurance required or provided by statute;
8. Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);

9. 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 herein. 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 such 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.

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

ARTICLE XIII.
PLAN AMENDMENT AND TERMINATION

13.1 **Amendments**. The Plan Sponsor reserves the right to amend the Plan, or any portion of the Plan, at any time. The Plan Sponsor expressly may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the law. Such amendments shall not affect any right to Benefits that accrued prior to such amendments. Such amendment shall be made in writing and in accordance with Section 14.4.

Any Insurer providing benefits under this Plan under the terms of a Coverage Contract may amend such Coverage Contract as and to the extent provided therein.

Where a change to a Coverage Contract affects the information described in one or more Exhibits, then the Exhibit may be updated in accordance with the change to the Coverage Contract without resorting to the formalities of a formal amendment. For example, if a Coverage Contract 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 may, without resorting to the formalities of a formal amendment, replace the Exhibits attached hereto with Exhibits reflecting the updated information regarding the Coverage Contract or its issuer.

13.2 **Plan Sponsor's Right to Terminate**. Although the Plan Sponsor expects the Plan to be maintained for an indefinite time, the Plan Sponsor reserves the right to terminate the Plan or any portion of the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Plan Sponsor, the Plan shall terminate unless the Plan is continued by a successor to the Plan Sponsor in accordance with the resolution of such successor's managing body. Such termination shall not affect any right to Benefits that accrued prior to such termination. Such action shall be taken in writing and in accordance with Section 14.4.

13.3 **Mergers and Acquisitions**. Notwithstanding the Component Plan eligibility requirements as stated in each Exhibit, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into the applicable Exhibit, and therefore the Plan, by reference.

ARTICLE XIV.
GENERAL PROVISIONS

14.1 **Plan Not a Contract of Employment**. The Plan is not an employment agreement and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in the Plan.

14.2 **No Right to Employer's Assets**. No Covered Individual or beneficiary thereof shall have any right to, or interest in, any assets of the Employer upon termination of employment, or otherwise except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Covered Individual or beneficiary thereof.

14.3 **Non-Alienation of Benefits**. Benefits payable under the Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the Benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to Benefits payable under the Plan shall be void. The Employer, Plan Administrator, and/or third party claims administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to Benefits under the Plan.

14.4 **Action by Employer**. Unless otherwise specifically stated in this Plan, whenever the Employer, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Employer or such representatives of the Employer as the managing body may designate.

14.5 **No Guarantee of Tax Consequences**. Notwithstanding any provision in the Plan to the contrary, neither the Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

14.6 **Indemnification of Employer by Participants**. To the maximum extent allowed by, and in accordance with, applicable law, if any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold including federal or state income tax or Social Security or Medicare tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security or Medicare tax that would have been paid on such compensation, less any such additional income and Social Security or Medicare tax actually paid by the Participant.

14.7 **Mistakes and Errors**. It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or

the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

14.8 **Limitation on Liability**. The Employer does not guarantee Benefits payable under any insurance policy described or referred to herein, and any Benefits thereunder shall be the exclusive responsibility of the insurer that is required to provide such Benefits.

14.9 **Additional Benefits**. Nothing under the Plan precludes the Employer from providing additional Benefits to a Participant who is also receiving Benefits under the Plan including, but not limited to, Benefits that require receipt of Benefits under the Plan as a pre-condition to receiving Benefits under such other plan or program. However, nothing in such other plan or program shall be construed as amending or in any other way influencing the administration of the Plan.

14.10 **Coordination with Coverage Contract(s)**. To the extent a Coverage Contract contains terms, conditions, etc. that conflict or are inconsistent with the Plan document, the terms of the Coverage Contract shall control, unless such terms are prohibited by or inconsistent with applicable law or the conflict or inconsistency is specifically addressed by this Plan. For this purpose, silence in a Coverage Contract is not necessarily a conflict or inconsistency.

14.11 **Gender and Number**. Pronoun references in this Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

14.12 **Governing Law**. This Plan shall be construed and enforced according to the laws of Ohio except to the extent preempted by federal law.

14.13 **Family and Medical Leave Act of 1993**. Notwithstanding any provision of the Plan to contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder. A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under the FMLA. This notice may be obtained from the Employer upon request, free of charge.

14.14 **Consolidated Omnibus Budget Reconciliation Act of 1985**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), and in accordance with any policies and procedures adopted by the Plan Administrator. A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under COBRA. This notice may be obtained from the Employer upon request, free of charge.

14.15 **Uniformed Services Employment and Reemployment Rights Act of 1994**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), and in accordance with any policies and procedures adopted by the Plan Administrator. A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under USERRA. This notice may be obtained from the Employer upon request, free of charge.

14.16 **Genetic Information Nondiscrimination Act of 2008**. Notwithstanding any provision of this Plan to contrary, and to the extent the Benefit is subject to this law, this Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of

2008 ("GINA"). A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under GINA. This notice may be obtained from the Employer upon request, free of charge.

14.17 **Qualified Medical Child Support Orders**. Notwithstanding any provision in the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall recognize Qualified Medical Child Support Orders ("QMCSOs"). The Plan has procedures for determining whether an order qualifies as a QMCSO, which may be obtained (free of charge) from the Employer upon request.

14.18 **Children's Health Insurance Program Reauthorization Act of 2009**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under CHIPRA. This notice may be obtained from the Employer upon request, free of charge.

14.19 **Michelle's Law**. Notwithstanding any provision of this Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner as required by Michelle's Law. A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under Michelle's Law. This notice may be obtained from the Employer upon request, free of charge.

14.20 **Mental Health Parity and Addiction Equity Act of 2008**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under the MHPAEA. This notice may be obtained from the Employer upon request, free of charge. You may also request information from your Plan Administrator regarding the nonquantitative treatment limitation (NQTL) analysis, as required for group health plans under the MHPAEA. To request this information, complete the Department of Labor form template found at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft.pdf and return the completed form to your Plan Administrator.

14.21 **Newborns' and Mothers' Health Protection Act of 1996**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"). A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under the NMHPA. This notice may be obtained from the Employer upon request, free of charge.

14.22 **Women's Health and Cancer Rights Act of 1998**. Notwithstanding any provision of the Plan to the contrary, and to the extent the Benefit is subject to this law, the Plan shall be operated and maintained in a manner consistent with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). A separate notification requirement applies under Federal law requiring Employers to provide notice(s) to employees summarizing their rights under the WHCRA. This notice may be obtained from the Employer upon request, free of charge.

14.23 **Health Care Reform**. To the extent the Plan is subject to the requirements of Health Care Reform, the Plan shall be operated and maintained in a manner consistent with Health Care Reform. A separate notification requirement applies under Federal law requiring Employers to

provide notice(s) to employees summarizing their rights under Health Care Reform. Notice(s) may be obtained from the Employer upon request, free of charge.

14.24 **No Estoppel of Plan**. No person is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the Plan and the applicable Benefit. The fact that payments have been made from the Plan in connection with any claim for benefits does not (a) establish the validity of the claim; (b) provide any right to have such benefits continue for any period of time; or (c) prevent the Plan from recovering benefits paid to the extent that the Claims Administrator or Plan Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid (whether or not attributable to an error by the Participant or any other person), then the Claims Administrator or Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation including, without limitation, by deducting the amount of any overpayment theretofore made to or on behalf of such Participant from any succeeding payments to or on behalf of such Participant under the Plan or from any amounts due or owning to such Participant by the Employer or under any other plan, program, or arrangement benefiting the Employees or former Employees of the Employer, or otherwise recovering such overpayment from whomever has benefited from it. If the Claims Administrator or Plan Administrator determines that an underpayment of benefits has been made, then the Claims Administrator or Plan Administrator shall take such action as it deems necessary or appropriate to remedy such a situation.

ARTICLE XV.
HIPAA PROVISIONS

The Privacy Rules and Security Rules under HIPAA apply to certain Benefits of the Plan that constitute "covered entities" within the meaning of HIPAA (e.g., employer sponsored group health plans). This Article XV applies to the Benefits of the Plan that are considered "covered entities" as indicated in a particular Benefit's Exhibit.

15.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent allowed by, and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Employer in accordance with this Article XV, the Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by the Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefits claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities, and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health plan); and

(13) Reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administration activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) customer service, including data analyses for policyholders.

(8) Resolution of internal grievances; and

(9) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

15.2 **Employer's Obligations under the Privacy Rules**. Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certify that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) Not use or disclose PHI in connection with any other benefit of the Employer unless authorized by an individual;

(e) Report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) Make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

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

15.3 **Employer's Obligations under Security Rules**. If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) Ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) Report to the Plan any Security Incident of which it becomes aware; and

(d) Implement reasonable and appropriate security measures to ensure that only those persons identified below have access to ePHI and that such access is limited to the purposes identified below.

15.4 **Adequate separation between the Plan and the Employer must be maintained**. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) The person employed in the position that is given primary responsibility for performing the Employer's duties as the Plan Administrator; and

(b) Staff of the Employer designated by the person described in (a) above.

15.5 **Limitation of PHI Access and Disclosure**. The person(s) described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.

15.6 **Noncompliance Issues**. If the person(s) described above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.

15.7 **Amendments and Guidance**. To the extent HIPAA is amended and/or enforcement agency guidance is issued after the Effective Date of this Plan, the Plan shall be administered in accordance with the law, including such amendments and/or changes.

EXHIBIT A. Employer and Plan Information

PART I. Employer Details

Employer and Plan Sponsor:	Lithko Contracting, LLC 2958 Crescentville Road West Chester, OH 45069 Phone: 855-412-0916
Employer Business Type:	Corporation
Employer Identification Number (EIN):	43-1214734
State of Incorporation:	Ohio
Employer subject to ERISA?	Yes
Commonly Controlled Entities:	As identified in **EXHIBIT A-1. Commonly Controlled Entities**

PART II. General Plan Information

Name of Plan:	Building Your Benefits Health & Welfare Plan
Plan Year:	January 1 through December 31
Plan Number:	505
Effective Date of Plan:	January 1, 2025
Original Effective Date of Plan:	January 1, 2020
Type of Plan:	The Plan provides comprehensive Medical, Dental, Vision, Group Life/AD&D, Long-Term Disability, Employee Assistance Program (EAP), Health Flexible Spending Account (FSA) benefits and is considered a "Health and Welfare Benefit Plan" under ERISA. The Plan also provides Short-Term Disability (Self Insured) benefits which are not subject to ERISA.
Plan Administrator:	Lithko Contracting, LLC 2958 Crescentville Road West Chester, OH 45069 Phone: 855-412-0916
Agent for Service of Legal Process:	Lithko Contracting, LLC 2958 Crescentville Road West Chester, OH 45069 Phone: 855-412-0916

	Legal process may also be served on the Plan Administrator or any Trustee with respect to disputes arising under the Plan.

EXHIBIT A-1: Commonly Controlled Entities

The Employer(s) listed below are also participating in the Building Your Benefits Health & Welfare Plan ("the Plan") sponsored by Lithko Contracting, LLC. Participating Employers are given the option to participate in all, or a portion of, Component Benefit Programs offered under the Plan.

Note: As Employers enter into the Plan or cease participating in the Plan, this Exhibit A-1 shall be amended accordingly.

Unlimited Contracting Solutions

11-1111111

Lithko TX

11-1111112

Pikus Concrete Contracting

11-1111113

Full Tilt Constructors

11-1111114

FrontLine Concrete Contracting

11-1111115

EXHIBIT B: Component Benefit Plans

Part I. Lithko Contracting, LLC Medical Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Medical Plan, which consists of one or more policy(ies) named below. • Medical Benefit - PPO 1500 • Medical Benefit - PPO 1250 • Medical Benefit - HDHP
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain health benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 104, 105, and 106 of the Code. It is also the intention of the Employer that this portion of the Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and Health Care Reform.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Medical Benefit - PPO 1500

Insurer/Provider Information	UMR
Component Plan Details and Eligibility Requirements	The Eligibility requirement and/or the Waiting Period to become eligible for this benefit may vary for different classes of Employees. See below for the requirements applicable to each class. **Employee Class Name:** Lithko Contracting Coworkers • **Eligible Employee:** Not eligible • **Waiting Period/Entry Date:** Not eligible **Employee Class Name:** All Lithko TX, UCS, Pikus, Full-Tilt, and Frontline Coworkers • **Eligible Employee:** Full Time employees working 30 hours per week • **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage **ACA Measurement Period:** As described in **Exhibit B-1. ACA Compliance Policy** **Eligibility for Rehired Employees:** As described in **Exhibit B-1. ACA Compliance Policy**
Funding Medium and Type of Plan Administration	This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trustee(s). Benefits are not paid through insurance contracts.

Medical Benefit - PPO 1250

Insurer/Provider Information	UMR
Component Plan Details and Eligibility Requirements	The Eligibility requirement and/or the Waiting Period to become eligible for this benefit may vary for different classes of Employees. See below for the requirements applicable to each class. **Employee Class Name:** Lithko Contracting Coworkers • **Eligible Employee:** Full Time employees working 30 hours per week • **Waiting Period/Entry Date:** 90 days following date of hire **Employee Class Name:** All Lithko TX, UCS, Pikus, Full-Tilt, and Frontline Coworkers

- **Eligible Employee:** Not eligible
- **Waiting Period/Entry Date:** Not Eligible

Spouse/Dependent Coverage: Legal Spouse and Dependent Child(ren)

Domestic Partner Coverage: No Domestic Partner Coverage

ACA Measurement Period: As described in **Exhibit B-1. ACA Compliance Policy**

Eligibility for Rehired Employees: As described in **Exhibit B-1. ACA Compliance Policy**

Funding Medium and Type of Plan Administration

This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trustee(s). Benefits are not paid through insurance contracts.

Medical Benefit - HDHP

Insurer/Provider Information

UMR

Component Plan Details and Eligibility Requirements

Eligible Employee: Full Time employees working 30 hours per week

Waiting Period/Entry Date: 90 days following date of hire

Spouse/Dependent Coverage: Legal Spouse and Dependent Child(ren)

Domestic Partner Coverage: No Domestic Partner Coverage

ACA Measurement Period: As described in **Exhibit B-1. ACA Compliance Policy**

Eligibility for Rehired Employees: As described in **Exhibit B-1. ACA Compliance Policy**

Funding Medium and Type of Plan Administration

This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trustee(s). Benefits are not paid through insurance contracts.

HIPAA Special Enrollment Rights

In certain cases, individuals are allowed to enroll in this Component Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (1) acquiring a spouse or dependent, (2) losing other group coverage, (3) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (4) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under Employer's group health plan. Please refer to the particular Coverage Contract for additional information regarding HIPAA special enrollment, including

information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under the Component Plan.

Application of HIPAA Privacy and Security Rules

This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules and will be administered in accordance with the HIPAA privacy and security provisions contained in the Coverage Contract and the privacy and security policies and procedures established for the covered entity.

Mergers and Acquisitions

Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.

Plan Interpretation

To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part II. Lithko Contracting, LLC Dental Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Dental Plan, which consists of one or more policy(ies) named below. • Dental Benefit
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain dental benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this portion of the Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and Health Care Reform. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from Health Care Reform.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Dental Benefit

Insurer/Provider Information	Delta Dental
Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Application of HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules and will be administered in accordance with the HIPAA privacy and security provisions contained in Article XV and the privacy and security policies and procedures established for the covered entity.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part III. Lithko Contracting, LLC Vision Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Vision Plan, which consists of one or more policy(ies) named below. • Vision Benefit
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain vision benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this portion of the Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and Health Care Reform. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from Health Care Reform.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract

Vision Benefit

Insurer/Provider Information	VSP
Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Application of HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules and will be administered in accordance with the HIPAA privacy and security provisions contained in the Covered Contract and the privacy and security policies and procedures established for the covered entity.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part IV. Lithko Contracting, LLC Life and/or AD&D Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Life and/or AD&D Plan, which consists of one or more policy(ies) named below. • Voluntary Life/AD&D • Basic Life/AD&D
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain life and accidental death and dismemberment benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as group term life insurance under Section 79 of the Code and/or accident benefits under Sections 104, 105, and 106 of the Code. It is also the intention of the Employer that this portion of the Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Voluntary Life/AD&D

Insurer/Provider	Lincoln National Life Insurance Company

Information

Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.

Basic Life/AD&D

Insurer/Provider Information	Lincoln National Life Insurance Company
Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** No Spouse or Dependent Coverage **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Insurer with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.

Plan Interpretation

To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part V. Lithko Contracting, LLC Long Term Disability Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Long-Term Disability Plan, which consists of one or more policy(ies) named below. • Long-Term Disability
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain disability benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 104, 105, and 106 of the Code. It is also the intention of the Employer that this portion of the Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA, unless required under applicable law.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Long-Term Disability

Insurer/Provider Information	Lincoln National Life Insurance Company

Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** No Spouse or Dependent Coverage **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Insurer with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part VIII. Lithko Contracting, LLC Short Term Disability Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Short-Term Disability (Self Insured) Plan, which consists of one or more policy(ies) named below. • Short-Term Disability
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain disability benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 104, 105, and 106 of the Code. It is also the intention of the Employer that this portion of the Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Short-Term Disability

Insurer/Provider Information	Lincoln National Life Insurance Company

Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** No Spouse or Dependent Coverage **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trustee(s). Benefits are not paid through insurance contracts. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

PART VI: Lithko Contracting, LLC Employee Assistance Program

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Employee Assistance Program (EAP) Plan, which consists of one or more policy(ies) named below. • Employee Assistance Program
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Insurer:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide employee assistance benefits for certain Eligible Employees. It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and Health Care Reform. Notwithstanding the foregoing, this Component Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from Health Care Reform.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Employee Assistance Program

Insurer/Provider Information	CompsPsych
Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer identified in the Insurer/Provider Information section of this Exhibit. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Application of HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules and will be administered in accordance with the HIPAA privacy and security provisions contained in Article XIV and the privacy and security policies and procedures established for the covered entity.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Part VII. Lithko Contracting, LLC Flexible Spending Account Plan

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Employee:	Shall have the same meaning as defined in Article II of the Plan.
Employer:	Shall have the same meaning as defined in Article II of the Plan.
Exhibit:	This Exhibit B, including all Parts, that is attached hereto and made part of the Plan.
Component Plan:	Lithko Contracting, LLC Flexible Spending Account Plan, which includes the below Plan option(s): • Health Flexible Spending Account (FSA)
Coverage Contract:	A separate document(s) attached hereto and incorporated herein that describes in detail the coverage and benefits provided by this Component Plan.
Provider:	Shall have the same meaning as defined in Article II of the Plan.
Plan:	Building Your Benefits Health & Welfare Plan

Purpose	The Employer has determined to provide certain health benefits for certain Eligible Employees. It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this portion of the Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and Health Care Reform. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from Health Care Reform.
Terms and Conditions of Coverage	The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Healthcare FSA

Insurer/Provider	Chard Snyder, a WEX Company

Information

Component Plan Details and Eligibility Requirements	**Eligible Employee:** Full Time employees working 30 hours per week **Waiting Period/Entry Date:** 90 days following date of hire **Spouse/Dependent Coverage:** Legal Spouse and Dependent Child(ren) **Domestic Partner Coverage:** No Domestic Partner Coverage
Funding Medium and Type of Plan Administration	This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets or, if applicable, the Plan Assets held in Trust by the Trustee(s). Benefits are not paid through insurance contracts. The Insurer (not the Employer or Plan Administrator) is responsible for administering claims and paying benefits. Note that the Insurer and the Plan Administrator share responsibility for administering the Component Plan, as discussed in Article XI of the Plan.
Application of HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules and will be administered in accordance with the HIPAA privacy and security provisions contained in Article XIV of the Plan and the privacy and security policies and procedures established for the covered entity.
Mergers and Acquisitions	Notwithstanding the Component Plan eligibility requirements as stated above, the Employer reserves the right to adjust the eligibility requirements for Employees acquired through a merger or acquisition of another, or related, company. Provided the Provider with respect to the Component Plan agrees to amend the eligibility requirements in the Coverage Contract for "acquired" Employees, the Plan is automatically amended to reflect the same, because the amended Coverage Contract is incorporated into this Exhibit, and therefore the Plan, by reference.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Exhibit B-1. Affordable Care Act Compliance Policy

Building Your Benefits Health & Welfare Plan

Provisions under the Affordable Care Act

Purpose. The Purpose of this Affordable Care Act Compliance Policy ("ACA Compliance Policy") is to describe the methods established by the Employer, Plascon, Inc. to remain compliant with the Affordable Care Act regulations regarding eligibility for health benefits.

The Patient Protection and Affordable Care Act ("PPACA" or "ACA") imposed rules for Applicable Large Employers ("ALE") that include, but are not limited to, definition and calculation of hours of service, classification of employees, eligibility determinations for health plans, and providing standards for plan affordability. The method(s) outlined in this policy apply specifically to benefit plans offering medical coverage.

Look-Back Measurement Period

1. Special Definitions

Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

For purposes of this ACA Compliance Policy, the following special definitions will apply:

(a) **Administrative Period** means an optional period after the end of a Measurement Period – and before the beginning of the Stability Period associated with the Measurement Period – during which the Employer can perform administrative tasks, such as calculating the hours worked for the Measurement Period, determining eligibility for coverage, providing enrollment materials to eligible employees, and conducting open enrollment activities.

(b) **Applicable Large Employer** means an employer that employed an average of at least 50 Full-Time Employees (including Non-Full-Time Employees ("Full-Time Equivalent" or "FTE") averaging at least 30 hours per week) during the preceding calendar year.

(c) **Employee** has the meaning set forth in the Plan.

(d) **Full-Time Employee** means an employee who averages at least 30 hours of service per week or 130 hours of service for the calendar month.

(e) **Hour of Service** means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the company; (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed (e.g., paid vacation, holiday, illness, disability, layoff, jury duty, military leave, paid leave of absence); and (3) each hour of unpaid leave that is subject to FMLA, USERRA, or on account of jury duty.

(f) **Initial Administrative Period** is the Administrative Period that follows the Initial Measurement Period and precedes the Initial Stability Period.

(g) **Initial Measurement Period** is the Measurement Period used for New Employees.

(h) **Initial Stability Period** is the Stability Period that begins after the completion of the Initial Measurement Period and Initial Administrative Period, if applicable, during which the full-time or part-time status achieved during the Initial Measurement Period shall apply.

(i) **Look-Back Measurement Method ("LBMM")** means the method in which an employee's full-time status during the stability period is based on their hours of service averaged over a preceding period, referred to as the measurement period.

(j) **Measurement Period** means the period of time during which Hours of Service are calculated to determine eligibility for the Plan health (i.e., medical) benefit(s) by determining whether the Employee has averaged at least 30 hours per week. There are two types of measurement periods: Standard Measurement Period and Initial Measurement Period.

(k) **New Employee** means an Employee who has not been employed for one complete Standard Measurement Period (i.e., an Employee in their Initial Measurement Period), or an Employee who was rehired after expiration of the parity period established for the plan.

(l) **Ongoing Employee** means an Employee who has been employed for at least one complete Standard Measurement Period, or an Employee who was rehired within the parity period established for the Plan.

(m) **Part-Time Employee** means an employee who works less than 30 hours per week.

(n) **Patient Protection and Affordable Care Act ("PPACA" or "ACA")** means the comprehensive health care reform law enacted on March 23, 2010, that provides numerous rights and protections making health coverage more accessible and affordable and imposes requirements on applicable Employers to offer affordable health coverage to Full Time Employees.

(o) **Seasonal Employee** means an employee who is hired into a position that works for 6 months or less annually.

(p) **Stability Period** means the period that follows, and is associated with, a particular measurement period. An Employee's full-time or part-time status (determined based on hours credited during the measurement period) generally is locked in for the full stability period, regardless of the Employee's actual hours worked during the Stability Period (provided that the Employee continues to be an employee during the Stability Period (and any Administrative Period, if applicable)).

(q) **Standard Administrative Period** is the Administrative Period that follows the Standard Measurement Period for Ongoing Employees.

(r) **Standard Measurement Period** is the measurement period used for Ongoing Employees.

(s) **Standard Stability Period** is the Stability Period that begins after the completion of the Standard Measurement Period and Standard Administrative Period, if applicable, during which the full-time or part-time status achieved during the Standard Measurement Period shall apply.

(t) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act OF 1993 (FMLA) or to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or on account of jury duty.

(u) **Variable Hour Employee** means an employee for which the Employer cannot determine that the employee is reasonably expected to work, on average, at least 30 hours per week.

2. Measurement Method.

Employees that are not hired into employment categories that may be reasonably expected to work a specific number of hours on average each week, also known as Variable Hour Employees, must have their hours worked measured and tracked to determine eligibility for health benefits. This tracking is done by the Plan Administrator using a measurement method, which has certain rules for the calculations applied to determine benefit eligibility.

The Employer has elected to use the Look-Back measurement method to determine whether each Variable Hour Employee has sufficient Hours of Service to obtain Full-Time status for purposes of group health plan coverage, based on rules adopted by the Internal Revenue Service (IRS) to comply with the Patient Protection and Affordable Care Act ("ACA"). Under this method, the Employer calculates the Hours of Service worked by each Variable Hour Employee in a prior period (i.e., the "measurement period") to determine the status of the Employee that shall apply in a future period (i.e., the "stability period"). The Employer may utilize an additional time period (i.e., the "administrative period") between the measurement and stability periods to complete

administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. To prevent gaps in coverage the administrative period may overlap with the prior year's stability period, during which time the Employee's classification of Full-Time or Part-Time status obtained during the prior year's measurement period shall continue to apply. Determination of Full-Time status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations.
For all Variable Hour Employees in the group All Employees, the Look-Back Measurement Method will apply to both New Employees and Ongoing Employees.

New Employees

New Employees will have their Hours of Service counted during an Initial Measurement Period of 12 months to determine whether they have worked an average of at least 30 hours per week if, based on the facts and circumstances at the Employee's date of hire, the Employer cannot determine whether the Employee is reasonably expected to work 30 hours per week (e.g., Variable Hour Employees, Seasonal Employees). Hours of Service will be counted as of the First of the month following date of hire. If the Employee satisfies the requirement and averages at least 30 hours worked per week, the Employee will then be offered health coverage by the end of the Initial Administrative Period, which may last up to 30 days. The coverage will then be effective for the entire duration of the Initial Stability Period, which lasts 12 months. Conversely, if the Employee does not satisfy the requirement and averages less than 30 hours worked per week, the Employee may not be offered health coverage after the Initial Measurement Period and will remain ineligible for the duration of the Initial Stability Period.

Each New Employee will have an Initial Measurement, Administrative, and Stability Period. Afterward, the Employee will be considered an Ongoing Employee and the Standard Measurement, Administrative, and Stability Periods will apply.

Ongoing Employees

Ongoing Employees will have their Hours of Service counted during the Standard Measurement Period of 12 months to determine whether they have worked an average of at least 30 hours per week during the measurement period. The Standard Measurement Period will generally begin and end on the same dates each calendar year, and the beginning of the Standard Stability Period will generally align with the beginning of the benefit Plan Year. If the Employee satisfies the requirement and averages at least 30 hours worked per week, the Employee will then be offered health coverage by the end of the Standard Administrative Period, which may last up to 90 days after the close of the Standard Measurement Period. The coverage will then be effective for the entire duration of the Standard Stability Period, which lasts for 12 months. Conversely, if the Employee does not satisfy the requirement and averages less than 30 hours worked per week, the Employee may not be offered health coverage after the Standard Measurement Period and will remain ineligible for the duration of the Standard Stability Period.

3. Change in Status

Special rules apply when an Employee experiences a change in employment status, depending on whether they are considered a new or ongoing employee and the circumstances surrounding the

change in status. The rules for the Look-back Measurement Method are complex and this is simply a general overview of how some of the rules apply. More complex rules may apply to your situation.

New Employees

The Look-back Measurement Method includes a special rule for Variable Hour Employees who experience a change in employment status during their Initial Measurement Period. This rule applies when an Employee changes from a Part-Time position to a Full-Time position and requires the Employer to provide coverage to the Employee (a) four calendar months following the change in employment status or (b) at the end of the Initial Measurement Period, including the Initial Administrative Period (if any), provided that the Employee averaged 30 hours of service per week during the Initial Measurement Period.

Ongoing Employees

Generally, the Look-back Measurement Method provides that Full-Time employee status in a stability period is based on Hours of Service in the previous applicable measurement period. If an Ongoing Employee has a change in employment status during a stability period, the change will not impact their Full-Time (or non-Full-Time) status during the remainder of the stability period in which the status change took place. Instead, that change in employment status will impact the Hours of Service applied to the current Standard Measurement Period.

Rehired Employees. Lithko allows rehired employees to resume benefits as is on the day they return within 12 months.