Tandem HR Welfare Benefits Plan

(Amended and Restated as of September 1, 2023)

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WHEREAS, Tandem HR, LLC ("Tandem HR") established this Tandem HR Welfare Benefits Plan ("Plan") as a "wrap plan" effective as of January 1, 2009, to consolidate the reporting and disclosure requirements of some of its welfare benefit plans; and

WHEREAS, Tandem HR, LLC established the Tandem HR Health & Welfare Benefits Plan ("Health & Welfare Plan"), effective as of January 1, 2010, as a wrap plan to integrate its other welfare benefit plans that were not included in the Plan; and

WHEREAS, Tandem HR acquired MidwestHR, LLC ("MidwestHR") in 2021; and

WHEREAS, MidwestHR's employees became participants in this Plan effective September 1, 2022; and

WHEREAS, MidwestHR's employees became participants in the Health & Welfare Plan, effective January 1, 2023; and

WHEREAS, QTI Human Resources, Inc. established the QTI Human Resources, Inc. Employee Benefits Plan ("QTI Plan"), effective as of January 1, 1996, as a wrap plan to consolidate the reporting and disclosure requirements of its welfare benefit plans; and

WHEREAS, Tandem HR acquired QTI Human Resources, Inc. September 3, 2021; and

WHEREAS, Tandem HR, LLC deems it necessary and desirable to merge this Plan with the Health & Welfare Plan and QTI Plan effective September 1, 2023, with this Plan surviving the merger, to incorporate all of the welfare benefit plans that comprise the Plan, the Health & Welfare Plan, and the QTI Plan into a single welfare benefit wrap plan and to further consolidate reporting and disclosure requirements; and

WHEREAS, concurrent with the merger of the Health & Welfare Plan into this Plan, Tandem HR deems it necessary and desirable to amend and restate the Plan effective as of September 1, 2023.

NOW, THEREFORE, effective September 1, 2023, Tandem Health HR hereby merges the Health & Welfare Plan and QTI Plan into the Plan with the Plan surviving the merger and amends and restates the Plan.

INTRODUCTION

This Plan document is intended to be read in conjunction with the Component Plans listed in Exhibit A It provides additional terms and conditions, and supplies

additional detail to, those provisions described in the Component Plans and their related insurance policies, Summary Plan Descriptions, and Summaries of Material Modification, as applicable. In the event of conflict between the terms of the documents related to the Component Plans listed in Exhibit A and this Plan document, the Plan document shall control.

ARTICLE 1 DEFINITIONS

Words and phrases used in this Plan shall have the meaning given to them below or in the other documents that comprise the Plan, including but not limited to the Component Plans in Exhibit A and Summary Plan Descriptions, unless the context clearly indicates otherwise.

1.1 Claims Representative. The organization or organizations designated by the Plan Sponsor to process claims and perform other Plan-related services.

1.2 Code. The Internal Revenue Code of 1986, as it may be amended from time to time.

1.3 Component Plan: Each of the benefits listed in Exhibit A, which collectively and in conjunction with this document comprise this Plan.

1.4 Eligible Employee. Any individual who renders services for which he or she is entitled to renumeration from the employer.

1.5 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

1.6 Participant. An Eligible Employee or former Eligible Employee who meets the eligibility requirements to participate in one or more of the Component Plans listed in Exhibit A and who has completed the enrollment materials in the form and manner prescribed by the Plan Administrator. An Eligible Employee or former Eligible Employee shall cease to be a Participant in this Plan when he or she is no longer covered by any Component Plan.

1.7 Plan. This Tandem HR Welfare Benefits Plan (Amended and Restated as of September 1, 2023) and the various Summary Plan Descriptions, insurance contracts, and other documents related to the Component Plans. A list of all Component Plans is attached hereto as Exhibit A. To the extent that a conflict exists between the terms of the Summary Plan Descriptions, insurance policies, and other Component Plan documents and this Plan document, this document shall control.

1.8 Plan Administrator. The Plan Sponsor, or any other entity that may succeed to the rights, powers, duties, and liabilities of the Plan Administrator under the Plan.

1.9 Plan Sponsor. Tandem HR, LLC, or any entity that may succeed to the rights, powers, duties, and liabilities of Tandem HR, LLC with respect to this Plan.

1.10 Plan Year. Prior to January 1, 2023, the twelve-month (12-month) period beginning each January 1 and ending the following December 31. Effective as of January 1, 2023, the eight-month (8-month) period beginning January 1, 2023, and

ending August 31, 2023. Effective as of September 1, 2023, the twelve-month (12-month) period beginning each September 1 and ending the following August 31.

1.11 Summary Plan Description. The booklet(s) prepared by or on behalf of the Plan Administrator describing in lay terms the provisions, procedures, and limitations of the Plan and the benefits offered under the Component Plans that apply to Eligible Employees according to the terms of their employment by the Plan Sponsor. This Plan incorporates all provisions contained in each applicable Summary Plan Description and any group insurance policy, if the Component Plan is insured.

ARTICLE 2 PARTICIPATION AND ELECTIONS

2.1 Eligibility. Eligibility and participation in the Plan are determined according to the terms and procedures set forth in the Component Plan documents applicable to an Eligible Employee.

(a) An Eligible Employee shall be eligible to participate in this Plan when he or she becomes eligible to participate in one or more Component Plans.

(b) Participation in this Plan shall cease when the Eligible Employee is no longer eligible to participate in any Component Plan.

2.2 FMLA Participants. A Participant whose coverage terminates during a qualified leave under the Family and Medical Leave Act of 1993 ("FMLA"), as amended from time to time, by reason of the Participant's election or due to non-payment of required employee contributions, will be eligible to participate in the Plan on the date he or she returns to employment as an Eligible Employee, provided that the individual re-enrolls by completing any required enrollment materials in the form and manner and within the time period prescribed by the Plan Administrator.

2.3 Military Leave Participants. A Participant who has satisfied the requirements for participation in the Plan prior to the time his or her coverage under the Plan is terminated by reason of military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended from time to time, and who is reemployed by an employer within the time allowed by law, will be immediately eligible to participate in the Plan as of the date of his or her reemployment as an Eligible Employee, provided that the individual re-enrolls by completing any required enrollment materials in the form and manner and within the time period prescribed by the Plan Administrator.

2.4 Medicaid-Eligible Participants.

(a) In enrolling a Participant or in determining or making any payments for benefits of a Participant, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

(b) Benefit payments under the Plan will be made in accordance with any assignment of rights made by or on behalf of a Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on August 10, 1993, and as amended from time to time).

(c) To the extent that a payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act for a Participant's medical services or supplies for which this Plan would have had a legal liability to pay, benefits under this Plan will be paid in accordance with any applicable state law which provides that the state has acquired the right to payment for such medical services or supplies.

2.5 Employee Elections. Each Eligible Employee will be given an opportunity to elect to participate in the Plan if such Eligible Employee meets the eligibility requirements to participate in one or more of the Component Plans. An Eligible Employee's election will remain in effect throughout the Plan Year, except that an Eligible Employee may make a new election as provided in the Tandem Professional Services, Inc. Section 125 Cafeteria Plan.

ARTICLE 3 CONTRIBUTIONS

3.1 Employer Contributions. Consistent with its funding policy and method, the Plan Sponsor shall make a contribution to the Plan in the amount and at the time determined by the Plan Administrator. The Plan Administrator's determination shall be based on the funding policy and method, the current number of Participants, the amount and type of insurance (if any) in force for each Participant, the actual amount of benefits paid under the Plan, and such other factors as the Plan Administrator deems pertinent.

3.2 Employee Contributions. Each Plan Year, the Plan Administrator shall determine the amount of employee contributions, if any, that Participants or any sub-group of Participants shall be required to pay for coverage under this Plan.

ARTICLE 4 PRIVACY REQUIREMENTS

4.1 General. This Article 7 is intended to comply with the requirements of Section 164.504(f) of HIPAA and its implementing Regulations by establishing the extent to which the Component Plans that are group health plans (collectively referred to below as the "Plan") or the Plan Sponsor will receive, use, and/or disclose Protected Health Information. Except as provided under Section 4.3(i), the Plan shall disclose Protected Health Information to the Plan Sponsor only if the requirements of this Article 3 are met.

4.2 Definitions.

(a) *Covered Entity* means an entity subject to the regulations enacted under HIPAA, including health care providers who transmit health information in an electronic form, health plans, and health care clearinghouses. The Plan is a Covered Entity.

(b) *Health Care Operations* means activities that include, but are not limited to, any of the following activities of the Plan to the extent that the activities are related to Plan functions:

(1) conducting quality assessment and improvement activities;

(2) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives, and related functions that do not include treatment;

(3) reviewing the competence of health care professionals and their performance, including accreditation, certification, licensing, or credentialing activities;

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

(5) conducting or arranging medical review, legal services, and auditing functions, 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 methods of payment, or coverage policies; and

(7) business management and general administrative activities of the Plan, such as:

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

(B) customer service, including provision of data analysis for policy holders, plan sponsors, or other customers, provided that Protected Health Information is not disclosed to such policy holder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence related to the sale, transfer, merger of the Plan to, or consolidation of all or part of the Plan with, another Covered Entity, or an entity that following such activity will become a Covered Entity.

(c) *HIPAA* means the Health Insurance Portability and Accountability Act of 1996.

(d) *Individual* means the person who is the subject of the Protected Health Information.

(e) *Individually Identifiable Health Information* means information that is a subset of health information, including demographic information collected from an individual, and that:

(1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, and

(2) relates to the past, present, or 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

(A) identifies the Individual; or

(B) with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

(f) *Organized Health Care Arrangement* means the Plan and one or

more other group health plans, each of which are maintained by the Plan Sponsor. Organized Health Care Arrangement also means health insurance issuers or health maintenance organizations ("HMOs") with respect to such group health plans, but only with respect to Protected Health Information created or received by such health insurance issuers HMOs that relates to Individuals who are or have been Participants in any of such group health plans.

(g) ***Payment*** means the activities undertaken by the Plan to obtain premiums or to determine or fulfill the Plan's responsibility for coverage and provision of benefits. These activities relate to the Participant to whom health care is provided. They include, but are not limited to:

(1) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(2) risk adjusting amounts due based on Participant health status and demographic characteristics;

(3) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing;

(4) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(5) utilization review activities, including precertification and preauthorization of services, concurrent, and retrospective review of services; and

(6) disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:

(A) name and address;

(B) date of birth;

(C) social security number;

(D) payment history;

(E) account number; and

(F) name and address of the health care provider and/or health plan.

(h) *Plan Administration Functions* means administration functions performed by the Plan Sponsor on behalf of the Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

(i) *Plan Sponsor* means, for purposes of this Article 3, Tandem HR, LLC or any entity that may succeed to the rights, powers, duties, and liabilities of Tandem HR, LLC with respect to this Plan.

(j) *Protected Health Information* means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media under 45 CFR Section 160.103, or transmitted or maintained in any other form or medium. Protected Health Information shall exclude Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. Section 1232g, records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv), employment records held by a Covered Entity in its role as employer, or regarding a person who has been deceased for more than fifty (50) years.

(k) *Regulations* means the Standards for Privacy of Individually Identifiable Health Information enacted in accordance with HIPAA at 45 Code of Federal Regulations (CFR) Parts 160 and 164, as amended from time to time.

(l) *Secretary* means the Secretary of the Department of Health and Human Services.

(m) *Treatment* means the coordination or management of health care and related services by one or more health care providers, the coordination or management of health care by a health care provider and a third party, consultation between health care providers relating to a patient, or the referral of a patient for health care from one health care provider to another.

4.3 Use and Disclosure of Protected Health Information.

(a) The Plan will use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the Regulations. Specifically, the Plan will use and disclose Protected Health Information for purposes related to Treatment, Payment, and Health Care Operations.

(b) The Plan will use and disclose Protected Health Information as required by federal and state law, including uses and disclosures required by the Secretary to investigate or determine the Plan's compliance with the Regulations.

(c) The Plan will disclose Protected Health Information to the Plan Sponsor for the purpose of administering employee benefit plans that are not Covered Entities only with a written authorization from the Participant.

(d) The Plan shall provide the Participant with the notice of privacy practices as required under 45 CFR Section 164.520. If notice is required, the Plan may provide the notice of privacy practices as a joint notice with another group health plan within an Organized Health Care Arrangement as provided in 45 CFR Section 164.520(d).

(e) The Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor agreeing to:

(1) not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;

(2) ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor that is not part of an Organized Health Care Arrangement unless authorized by a Participant;

(4) report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures provided in Section 4.3(a) of which it becomes aware;

(5) make available Protected Health Information only in accordance with 45 CFR Section 164.524;

(6) make available Protected Health Information for amendment and incorporate any amendments to the Protected Health Information in accordance with 45 CFR Section 164.526;

(7) make available Protected Health Information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(8) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA and the Regulations;

(9) if feasible, return or destroy all Protected Health Information received from the Plan and retain no copies of such Protected Health Information 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); and

(10) ensure that adequate separation required in 45 CFR Section 164.504(f)(2)(iii) is established.

(f) Protected Health Information shall be disclosed only to the following employees or classes of employees: only the Employee Benefits Contact and employees trained in the federal privacy rule.

(g) Employees described in Section 4.3(f) shall access and use Protected Health Information only for purposes of Plan Administration Functions.

(h) In the event of noncompliance with the provisions of this Article 3 by the persons described in Section 4.3(f), the Plan Administrator shall take measures depending on the severity of the breach, including reprimand, suspension without pay, and termination of employment in appropriate cases.

(i) The Plan may disclose the following information to the Plan Sponsor without regard to the above provisions of this Article 3:

(1) Information on whether an Individual is participating in the Plan.

(2) Summary health information, as defined in 45 CFR Section 164.504(a), at the Plan Sponsor's request for purposes of obtaining premium bids for providing health insurance coverage or modifying, amending, or terminating this Plan.

4.4 Electronic Security.

(a) The Plan Sponsor shall:

(1) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of a health care plan;

(2) ensure that the adequate separation required by 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(4) report to the applicable health care plan any security incident of which it becomes aware.

(b) Definitions. For the purposes of this Section 4.4, the following definitions shall apply:

(1) *Administrative safeguard*: Administrative actions, policies, and procedures to manage the selection, development, implementation, and maintenance of security measures to protect electronic Protected Health Information and to manage the conduct of a health care plan's workforce in relation to the protection of that information.

(2) *Physical safeguard*: Physical measures, policies, and procedures to protect the health care plan's electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion.

(3) *Security incident*: The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(4) *Security measures*: All of the administrative, physical, and technical safeguards in an information system.

(5) *Technical safeguard*: The technology and the policy and procedures for its use that protect electronic Protected Health Information and control access to it.

4.5 Notification of Breach of Unsecured PHI.

(a) Definitions. For the purposes of this Section 4.5, the following definitions shall apply:

(1) *Breach*. The unauthorized acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the HIPAA privacy rule that compromises the security or privacy of Protected Health Information. Notwithstanding the foregoing, the following shall not constitute a breach for the purposes of this Section 4.5.

(A) Unintentional acquisition, access, or use of Protected Health Information by an employee or individual acting under the authority of the Plan or business associate.

(B) Inadvertent disclosure of Protected Health Information from one person authorized to access Protected Health Information at the Plan or business associate to another person authorized to access Protected Health Information at the Plan or business associate.

(C) Unauthorized disclosures in which an unauthorized person to whom Protected Health Information is disclosed would not reasonably have been able to retain the information.

(2) *To compromise the security or privacy of Protected Health Information*. To pose a significant risk of financial, reputational, or other harm to the individual.

(3) *Unsecured PHI*. Protected Health Information that is not secured through use of technology or methodology specified by applicable federal guidance (generally, either encryption or destruction).

(b) Notification to Individuals. Following a breach of unsecured PHI, the Plan shall notify affected individuals in the manner and time frame required by HIPAA and applicable Regulations.

(1) The Plan shall notify each individual whose unsecured PHI has been or is reasonably believed by the Plan to have been accessed, acquired, used, or disclosed as a result of the breach. If an individual is deceased, notice shall be provided to next of kin or personal representative.

(2) The Plan shall provide the required notification without unreasonable delay and in no case later than sixty (60) calendar days after breach was discovered. A breach shall be treated as discovered by the Plan as of the first day the breach was known to the Plan or would have been known to the Plan if the Plan had exercised reasonable diligence.

(3) The notification shall contain the following elements:

(A) A brief description of the breach, including the date of the breach and the date of discovery.

(B) A description of the types of unsecured PHI that were involved in the breach.

(C) Any steps individuals should take to protect themselves from potential harm resulting from the breach.

(D) A brief description of steps the Plan is taking to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.

(E) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

(4) The notice shall be written in plain language, at an appropriate reading level, using clear language and syntax. The notice shall not include extraneous information that might diminish the message of the notice.

(5) The notice shall be delivered by first-class mail to last known address of individual or by electronic mail, provided the individual has agreed to receive electronic mail and that agreement has not been withdrawn.

(A) If there are fewer than ten (10) individuals for whom the Plan has insufficient or out-of-date contact information to provide the written notice, substitute notice shall be provided in accordance with applicable Regulations.

(B) If the Plan has insufficient or out-of-date contact information for ten (10) or more individuals, then substitute notice shall be provided through either:

(i) a conspicuous posting for a period of ninety (90) days on the home page of the Plan's website; or

(ii) conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.

In addition the Plan shall have a toll-free number, active for ninety (90) days, where an individual can learn whether the individual's unsecured PHI may be included in the breach.

(c) Notification to the Media.

(1) Notice to media shall be required if the breach involves the unsecured PHI of more than five hundred (500) residents of a state or jurisdiction. For this purpose a jurisdiction is a geographic area smaller than a state, such as a county, city, or town.

(2) Notice shall be provided in the time frame specified in Section 4.5(b)(2).

(3) Notice shall contain the information required under Section 4.5(b)(3).

(d) Notification to Secretary of Health and Human Services.

(1) For breaches involving five hundred (500) or more individuals (whether or not from the same state or jurisdiction), the Plan shall notify the Secretary concurrently with the notifications sent to the individuals.

(2) For breaches involving fewer than five hundred (500) individuals, the Plan shall keep a log or other documentation of the breaches, which shall be submitted to the Secretary within sixty (60) days after the end of each calendar year. Such log or other documentation shall be retained for six (6) years.

(e) Notification by Business Associate. A business associate shall provide a notice of breach of unsecured PHI to the Plan without unreasonable delay and in no case later than sixty (60) days following the breach. The Plan shall provide notice to the affected individuals without unreasonable delay but no later than the time specified in Section 4.5(e)(1) or (2) below:

(1) If the business associate is acting as an agent of the Plan, then the business associate's discovery of the breach shall be imputed to the Plan, and the Plan shall notify affected individuals no later than sixty (60) days after discovery of the breach by the business associate.

(2) If the business associate is an independent contractor of the Plan (not an agent), then the Plan shall provide notification to affected individuals no later than sixty (60) days after the date on which the business associate notifies the Plan of the breach.

ARTICLE 5 ADMINISTRATION

5.1 Named Fiduciaries.

(a) The Plan Sponsor, the Plan Administrator, if different, and the appeal review committee, if any, shall constitute named fiduciaries of the Plan for purposes of ERISA.

(b) A named fiduciary may appoint in writing other persons or entities to perform any of its duties and responsibilities. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Each fiduciary shall be accountable only for those responsibilities allocated to it hereunder.

5.2 Rules Relating to Fiduciaries Generally.

(a) Fiduciaries shall have only those specific and express powers, duties, responsibilities, and obligations as are specifically assigned to them under this Plan. It is intended under this Plan that each fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of any other fiduciary, unless:

(1) the fiduciary knowingly participated in or knowingly undertook to conceal the act or failure to act of another fiduciary;

(2) the fiduciary knew the act or failure to act was a breach of fiduciary responsibility by the other fiduciary and failed to make reasonable efforts to remedy the breach; or

(3) the fiduciary's breach of his or her own fiduciary responsibilities enabled the other fiduciary to commit a breach.

(b) Each fiduciary shall give directions, furnish information, and take action only in accordance with the provisions of this Plan, authorizing or providing for such directions, information, or action. Each fiduciary may rely upon any such directions, information, or action of any other fiduciary as proper under this Plan, and no fiduciary is required under this Plan to inquire into the propriety of any such directions, information, or action of any other fiduciary.

(c) Each fiduciary shall be entitled to such reasonable compensation for its services rendered as fiduciary as such fiduciary and the Plan Sponsor may agree, provided that no fiduciary who receives full-time pay from the Plan Sponsor for other services shall receive any remuneration as fiduciary.

(d) Any person or group of persons may serve in more than one fiduciary capacity.

5.3 Plan Administrator.

(a) The Plan Administrator shall be responsible for the day-to-day administration of the Plan. The Plan Administrator may appoint in writing other persons or entities to perform any of its fiduciary functions. The Plan Administrator and any such appointees may employ advisors and other persons necessary to help carry out their fiduciary responsibilities.

(b) The Plan Administrator shall have sole responsibility for the administration of the Plan as expressly described in the Plan. The Plan Administrator shall administer the Plan in accordance with its terms and shall have all power necessary to carry out the provisions of the Plan. The Plan Administrator shall have discretionary authority to interpret the Plan and shall determine all questions arising in the administration, interpretation, and application of the Plan and resolve any ambiguity, supply any omission, and reconcile any inconsistency in such manner and to such extent as the Plan Administrator deems proper. Any interpretation or construction placed upon any term or provision of the Plan by the Plan Administrator, any decisions and determinations of the Plan Administrator arising under the Plan, including without limiting the foregoing, the eligibility of an Eligible Employee or former Eligible Employee to become or remain a Participant hereunder, and the rights of Participants to benefits under the terms of the Plan, and any other action or determination or decision whatsoever taken or made by the Plan Administrator in good faith shall be final, conclusive, and binding upon all persons concerned, and shall not be reversed unless such decisions are arbitrary or capricious. The Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

(c) The Plan Sponsor agrees to indemnify and to defend to the fullest extent permitted by law any employee or former employee who serves or served as the Plan Administrator or its designee against all liabilities, damages, costs, and expenses occasioned by any good faith act or failure to act in connection with the Plan. This indemnification shall be limited to the costs and expenses not reimbursed under any fiduciary insurance provided by the Plan Sponsor. Expenses shall include attorneys' fees and amounts paid in settlement of any claims approved by the Plan Administrator.

5.4 Administrative Services. Administrative services with respect to the Plan may be provided by a Claims Representative pursuant to an agreement with the Plan Sponsor. By reference, any documents comprising such agreement shall also be made a part of this Plan.

5.5 Funding Policy.

(a) All benefits paid under the Plan that are insured shall be paid under a policy issued to the Plan Sponsor by one or more insurance companies or managed care organizations selected by the Plan Sponsor.

(b) All benefits paid by the Plan that are self-insured benefits shall be paid from the general assets of the Plan Sponsor.

(c) Nothing in the Plan is intended to require the establishment of a trust.

(d) The Plan Sponsor shall establish a "funding policy and method" whereby it shall determine the Plan's need for liquidity, the need for reserves, and the funding needs of the Plan to meet the commitments under any insurance contract or policy. The funding policy and method shall be consistent with the objectives of this Plan and with the requirements of Title I of ERISA. The Plan Sponsor may appoint a qualified person to establish the funding policy and method. Nothing herein shall be construed to require the Plan Sponsor or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

5.6 Books and Records; Disclosures.

(a) The Plan Administrator shall keep such books, records, and other data as it deems necessary for proper administration of the Plan, including but not limited to records related to the determination of each Eligible Employee's eligibility to participate hereunder.

(b) The records of the Plan Administrator shall be conclusive on all persons unless proved incorrect to the satisfaction of the Plan Sponsor or the Plan Administrator furnishing the same.

(c) The Plan Administrator shall comply with all reporting and disclosure requirements of the law and shall maintain all records required by law.

(d) The Plan Administrator shall supply all information and reports to Eligible Employees, eligible dependents, Participants, beneficiaries, and others as required by law.

(e) The Plan Administrator shall make available to each Eligible Employee such of his or her records under the Plan as pertain to him or her and which are required by law to be disclosed upon request, for examination at reasonable times during normal business hours.

ARTICLE 6 CLAIM AND CLAIM REVIEW PROCEDURES

6.1 Claims Representative. The Plan Administrator hereby designates the Claims Representative of each Component Plan listed on Exhibit A as its agent with respect to the duties and responsibilities of reviewing claims under the Plan.

6.2 Claim Procedure. Participants are entitled to have any claim under a Component Plan reviewed by the Claims Representative for that Component Plan. The Claims Representative is obligated to hear and resolve all claims in an equitable manner according to the procedures contained in the relevant Component Plan. The Claims Representative for each Component Plan shall establish and maintain reasonable procedures governing the filing of benefit claims as required under 29 CFR Section 2560.503-1(b) and shall notify Participants of such procedures.

(b) A description of such procedures and the applicable time frames shall be included in a Summary Plan Description satisfying the requirements of 29 CFR Section 2520.102-3.

(c) The claims procedures shall not inhibit or hamper the initiation or processing of a claim for benefits.

(d) The claims procedures shall permit an authorized representative of the claimant to act on behalf of the claimant in pursuing a claim for benefits or an appeal of an Adverse Benefit Determination.

(e) The claims procedures shall contain administrative safeguards to ensure compliance with the provisions of 29 CFR Section 2560.503-1.

6.3 Appeal Procedure. Claims under a Component Plan that are wholly or partially denied may be appealed in accordance with the procedures contained in that Component Plan.

6.4 ERISA Claim and Claim Review Procedures For Health Care Benefits. If the following procedures conflict with the claim and claim review procedures of any Component Plan, the claim and claim review procedures of the Component Plan shall govern to the extent that the Component Plan's procedures are consistent with ERISA. To the extent that such claim and claim review procedures of the Component Plan are not consistent with ERISA, the following procedures shall govern.

(a) Definitions.

(1) *Urgent Care Claim* means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim shall be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Notwithstanding the foregoing sentence, any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this Article 6.

(2) *Pre-Service Claim* means any claim for a benefit with respect to which the terms of the Plan condition payment of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) *Post-Service Claim* means any claim for a benefit that is not a Pre-Service Claim.

(4) *Adverse Benefit Determination* means any of the following:

(A) a denial, reduction, or termination of or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan;

(B) a denial, reduction, or termination of or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review;

(C) a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(D) if the Plan is a plan subject to the Patient Protection and Affordable Care Act, any rescission of coverage as described in 26 CFR Section 54.9815-2712(a)(2), whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

(5) *Notice or Notification* means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR Section 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) *Health Care Professional* means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

(b) Failure to Follow Claim Procedures.

(1) If a claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or the claimant's authorized representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This Notification shall be provided to the claimant or authorized representative as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to properly file an Urgent Care Claim) following the failure. Notification may be oral, unless written Notification is requested by the claimant or the claimant's authorized representative.

(2) This Section 6.4 shall apply only in the case of a failure that

(A) Is a communication by a claimant or the authorized representative of the claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(c) Timing of Notification of Benefit Determination.

(1) Urgent Care Claims**.** In the case of an Urgent Care Claim, the Claims Representative shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account

the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Plan. Notwithstanding the foregoing sentence:

(A) If the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Representative shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

(B) The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

(C) The Claims Representative shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

(i) the Plan's receipt of the specified information; or

(ii) the end of the period afforded the claimant to provide the specified additional information.

(2) Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(A) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claims Representative shall notify the claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Representative shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(C) Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Sections 6.4(d) and 6.4(e), and appeal shall be governed by Sections 6.4(f) through 6.4(n).

(3) Other Claims. In the case of a claim not described in Section 6.4(c)(1) or 6.4(c)(2), the Claims Representative shall notify the claimant of the Plan's benefit determination in accordance with the following:

(A) *Pre-Service Claims.* In the case of a Pre-Service Claim, the Claims Representative shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan.

(i) This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Representative both:

(1) determines that such an extension is necessary due to matters beyond the control of the Plan; and

(2) notifies the claimant, prior to the expiration of the initial fifteen-day (15-day) period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(ii) If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

(iii) Notification of any Adverse Benefit Determination shall be made in accordance with Sections 6.4(d) and 6.4(e).

(B) *Post-Service Claims.* In the case of a Post-Service Claim, the Claims Representative shall notify the claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim.

(i) This period may be extended one time for up to fifteen (15) days, provided that the Claims Representative both:

(1) determines that such an extension is necessary due to matters beyond the control of the Plan: and

(2) notifies the claimant, prior to the expiration of the initial thirty-day (30-day) period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(ii) If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

(d) Manner and Content of Notification of Benefit Determination. Except as provided in Section 6.4(d)(9) below, the Claims Representative shall provide a claimant with written or electronic Notification of any Adverse Benefit Determination. Any electronic Notification shall comply with the standards imposed by 29 CFR Section 2520.104b-1(c). The Notification shall set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the Adverse Benefit Determination;

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

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

(5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(6) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(7) the denial code and its corresponding meaning, the treatment code and its corresponding meaning, and the Plan's standard, if any, that was used in denying the claim;

(8) in the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims; and

(9) in the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described in this Section 6.4(d) may be provided to the claimant orally within the time frame prescribed in Section 6.4(c)(1), provided that a written or electronic Notification is furnished to the claimant not later than three (3) days after the oral Notification.

(e) A claimant may appeal the decision of the Claims Representative in writing to the Claims Representative within one hundred eighty (180) days following receipt of a Notification of an Adverse Benefit Determination.

(f) The review of an Adverse Benefit Determination shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by an appropriate named fiduciary of the Plan whom is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

(h) The Claims Representative shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

(i) Upon written request, the Participant (or the Participant's authorized representative) will be provided reasonable access to and copies of all documents, records, and other information relevant to the claim appeal. The Participant (or the Participant's authorized representative) will have the opportunity to review the claim file and present evidence and testimony. In addition, if the Claims Representative (1) considers, relies upon, or generates any new evidence in connection with a Participant's claim, or (2) bases an appeal decision on any new or additional rationale, the Claims Representative will provide the evidence or rationale to the Participant (or the Participant's authorized representative), free of charge, sufficiently in advance of its decision deadline to give the Participant (or the Participant's authorized representative) a reasonable opportunity to respond before that deadline.

(j) An expedited review process shall apply in the case of an Urgent Care Claim.

(1) A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant.

(2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Claims Representative and the claimant by telephone, facsimile, or other available similarly expeditious method.

(k) Timing of Notification of Benefit Determination on Review. The Claims Representative shall notify a claimant of the Plan's benefit determination on review within the times set forth in this Section 6.4(k).

(1) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Representative shall notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan.

(2) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Representative shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(3) Post-Service Claims. In the case of a Post-Service Claim, the Claims Representative shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(l) Manner and Content of Notification of Benefit Determination on Review.

(1) The Claims Representative shall provide a claimant with written or electronic Notification of a Plan's benefit determination on review. Any electronic Notification shall comply with the standards imposed by 29 CFR Sections 2520.104b-1(c).

(2) In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the claimant:

(A) the specific reason or reasons for the Adverse Benefit Determination;

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

(C) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits including the claimant's claim file;

(D) a statement of the claimant's right to bring an action under Section 502(a) of ERISA;

(E) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and

(F) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(m) The decision of the Claims Representative will be final and irrevocable and binding on all parties.

(n) Additional Provisions under the Patient Protection and Affordable Care Act. The provisions of this Section 6.4(n) will be effective only if the Component Plan is a health care plan subject to the Patient Protection and Affordable Care Act.

(1) The Claims Representative shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claimant's claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the Adverse Benefit Determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(2) Before the Claims Representative shall issue a final Adverse Benefit Determination based upon a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the Adverse Benefit Determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(3) The Claims Representative shall insure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons involved in making the decision.

(4) Notices provided by the Claims Representative in the event of an Adverse Benefit Determination or an Adverse Benefit Determination upon review shall include information sufficient to identify the claim involved, including:

(A) date of service;

(B) health care provider;

(C) claim amount, if applicable;

(D) diagnosis code and its corresponding meaning; and

(E) treatment code and its corresponding meaning.

(5) An Adverse Benefit Determination upon review shall include the denial code and its corresponding meaning as well as a description of the plan's standard that was used in denying the claim. This description shall include a discussion of the decision.

(6) The Claims Representative shall provide the claimant with a description of internal appeals and external review processes, including information respecting how to initiate an appeal.

(7) The Claims Representative shall disclose the availability of and contact any information for any office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist claimants with claims and appeals.

(8) If the Claims Representative does not strictly adhere to the requirements described in this Section 6.4(n), the claimant shall be deemed to have exhausted his internal claim and appeals process and shall be entitled to any available remedies under Section 502(a) of ERISA or under state law.

(9) The health care plan shall continue to provide coverage to the claimant pending the outcome of an appeal.

(10) The health care plan shall comply with external review processes under state or federal law as described in 29 CFR Section 2590.715-2719(c) or (d), as applicable.

6.5 External Review Procedure For Health Benefits. The following rules shall apply to any Component Plan that is subject to the Patient Protection and Affordable Care Act of 2010.

(a) Request for external review. A claimant may file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. (For this purpose, an "Adverse Benefit Determination" shall include rescission of coverage, in addition to the adverse benefit determinations defined in 29 CFR Section 2560.503-1.) If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request shall be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request shall be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

(b) Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

(1) the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(2) the Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the

requirements for eligibility under the terms of the Plan (*e.g.*, worker classification or similar determination).

(3) the claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the Plan's internal appeal process, as provided under 29 CFR Section 2590.715-2719(b)(2)(ii)(F); and

(4) the claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA(3272)). If the request is not complete, the notification shall describe the information needed to make the request complete and the Plan shall allow the claimant to perfect the request for external review within the four-month (4-month) filing period or within the forty-eight-hour (48-hour) period following the receipt of the notification, whichever is later.

(c) Referral to Independent Review Organization. The Plan shall assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and shall rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a Plan and an IRO must provide the following:

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(2) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO shall consider when conducting the external review. The IRO is not required to but may accept and consider additional information submitted after ten (10) business days.

(3) Within five (5) business days after the date of assignment of the IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final

internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information shall not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the claimant and the Plan.

(4) Upon receipt of any information submitted by the claimant, the assigned IRO shall within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Plan shall not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan shall provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) the claimant's medical records;

(B) the attending health care professional's recommendation;

(C) reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;

(D) the terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(E) appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice

guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) the opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(6) The assigned IRO shall provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO shall deliver the notice of final external review decision to the claimant and the Plan.

(7) The assigned IRO’s decision notice will contain:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant;

(F) A statement that judicial review may be available to the claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or

ombudsman established under Section 2793 of the Public Health Service Act.

(8) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six (6) years. An IRO shall make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request except where such disclosure would violate state or federal privacy laws.

(d) Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan immediately shall provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

6.6 Expedited External Review for Health Benefits.

(a) Request for expedited external review. A claimant may make a request for an expedited external review with the Plan at the time the claimant receives:

(1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under 29 CFR Section 2590.715-2719(b)(2)(ii)(B) would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed for an expedited internal appeal; or

(2) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which for which the claimant received emergency services, but has not been discharged from a facility.

(b) Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements set forth in Section 6.5(b) for standard external review. The Plan shall immediately send a notice that meets the requirements set forth in Section 6.5(b) for standard external review to the claimant of its eligibility determination.

(c) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in Section 6.5(c) for standard review. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse

Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(d) Notice of final external review decision. The Plan's contract with the assigned IRO shall require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in Section 6.5(d), as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO shall provide written confirmation of the decision to the claimant and the Plan.

6.7 ERISA Claim and Claim Review Procedures for Component Plans Offering Disability Benefits.

(a) Timing of Adverse Benefit Determinations.

(1) The Claims Representative shall notify the claimant of the disability plan's Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Claims Representative.

(2) This period may be extended for up to thirty (30) days, provided that the Claims Representative determines that an extension of time for processing is required due to circumstances beyond the control of the Claims Representative and notifies the claimant prior to the expiration of the initial forty-five-day (45-day) period of the circumstances requiring the extension of time and the date by which the Claims Representative expects to render a decision.

(3) If, prior to the end of the first thirty-day (30-day) extension, the Claims Representative determines that due to matters beyond its control, a decision cannot be rendered within the extension period, the period for making the decision may be extended for up to an additional thirty (30) days, provided that the Claims Representative notifies the claimant prior to the expiration of the first thirty-day (30-day) extension period of the circumstances requiring the extension and the date as of which the Claims Representative expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those

issues. The claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

(b) Notification of an Adverse Benefit Determination shall include the following information:

(1) the specific reason or reasons for the Adverse Benefit Determination;

(2) reference to the specific plan provisions on which the determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

(5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request; and

(6) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request;

(c) A claimant may appeal the decision of the Claims Representative in writing to the Claims Representative within one hundred eighty (180) days following receipt of a Notification of an Adverse Benefit Determination.

(d) The review of an Adverse Benefit Determination shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

(e) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(f) The Claims Representative shall identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

(g) Any health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

(h) Timing of Notification of Benefit Determination on Review. The Claims Representative of a disability plan shall notify the claimant of the determination on review within a reasonable period of time but not later than forty-five (45) days after the Claims Representative's receipt of the claimant's request for review.

(i) The Claims Representative shall provide the claimant with written or electronic notification of the plan's determination. In the case of an Adverse Benefit Determination on review, the notification will set forth the following information:

(1) the specific reason or reasons for the Adverse Benefit Determination;

(2) reference to the specific plan provisions on which the benefit determination is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

(4) a statement of the claimant's right to bring an action under Section 502(a) of ERISA;

(5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion shall be provided free of charge to the claimant upon request; and

(6) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

6.8 ERISA Claim and Claim Review Procedures for Benefits Under Component Plans Other than Health and Disability Plans.

(a) If a claim for benefits other than health or disability benefits under a Component Plan is wholly or partly denied, the Claims Representative shall notify the claimant of the plan's Adverse Benefit Determination within a reasonable period of time but not later than ninety (90) days after receipt of the claim by the Claims Representative, unless the Claims Representative determines that special circumstances require an extension of time for processing the claim.

(b) If the Claims Representative determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior the expiration of the initial ninety-day (90-day) period. In no event shall such an extension exceed a period of ninety (90) days beyond the end of the initial period. The notice shall indicate the special circumstances requiring the extension of time and the date by which the Claims Representative expects to render a benefit determination.

(c) The notice of an Adverse Benefit Determination shall include the following information:

(1) the specific reason or reasons for the Adverse Benefit Determination;

(2) reference to the specific plan provisions on which the determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review.

(d) The claimant shall have a period of sixty (60) days following receipt of the Adverse Benefit Determination in which to appeal the determination.

(e) The Claims Representative shall notify the claimant of the determination on review within a reasonable period of time, but not later than sixty (60) days following the Claims Representative's request for review, unless the Claims Representative determines that an extension of time for processing is required.

(f) If an extension of time for processing is required, the Claims Representative shall provide the claimant with notice of the extension prior to the expiration of the initial sixty-day (60-day) review period. In no event shall the extension period exceed a period of sixty (60) days following the end of the initial review period. The notice shall indicate the special circumstances requiring the extension and the date by which the Claims Representative expects to render a decision.

(g) The Claims Representative shall provide the claimant with written or electronic notification of the plan's determination. In the case of an Adverse Benefit Determination on review, the notification will set forth the following information:

(1) the specific reason or reasons for the Adverse Benefit Determination;

(2) reference to the specific plan provisions on which the benefit determination is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and

(4) a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

6.9 Limitation on Legal Action.

(a) Except as may be provided in Section 6.4(n)(8), no legal action can be maintained against any Component Plan, the Plan Sponsor, the Plan Administrator, or any fiduciary until the claimant has exhausted the claim procedures set forth in the applicable Component Plan(s) and this Article 6.

(b) No legal action may be maintained with respect to a claim against any component plan, the Plan Sponsor, the Plan Administrator, or any fiduciary after the date that is twelve (12) months after the claimant is notified of a final decision regarding the claim. The limitation set forth in this Section 6.9(b) shall apply notwithstanding anything to the contrary in this Plan or in any other document relating to the Plan. In the event of any inconsistency between this Section 6.9(b) and any other provision of this Plan or any other document relating to the Plan, the terms of this Section 6.9(b) shall govern.

ARTICLE 7 CONTINUATION OF HEALTH CARE COVERAGE

7.1 Continuation of Health Care Coverage. Notwithstanding any other provision of this Plan, a Qualified Beneficiary who would otherwise lose health care coverage under this Plan as a result of a Qualifying Event is entitled to elect health care continuation coverage under this Plan.

7.2 Definitions. For purposes of this Article 7 the following terms shall have the meaning given them as follows:

(a) Qualified Beneficiary means any individual who is the spouse of a Participant or the dependent child of a Participant and who is covered under a Health Care Plan on the day before a Qualifying Event. In the case of a Qualifying Event involving the termination or reduction of hours of a Participant's employment, the term "Qualified Beneficiary" also includes the Participant. A child born to or placed for adoption with a former Participant during the period of continuation coverage shall also be a Qualified Beneficiary for all purposes.

(b) Qualifying Event means any of the following events that results in the loss of coverage under the Health Care Plan for a Qualified Beneficiary and/or Participant:

(1) the death of the Participant;

(2) the termination (other than by reason of the Participant's gross misconduct), or reduction of hours, of the Participant’s employment;

(3) the divorce or legal separation of the Participant;

(4) the Participant’s becoming entitled to benefits under Medicare, Title XVIII of the United States Social Security Act;

(5) a dependent child’s ceasing to be a dependent as defined under a health care plan; or

(6) a proceeding under the federal bankruptcy laws, Title 11 of the United States Code with respect to the Employer from whose employment the Participant retired at any time;

(c) Employer means the Plan Sponsor and other entities that are members of a group described in Section 414(b), (c), (m), or (o) of the Code.

7.3 Term of Coverage. Continuation coverage offered to any Qualified Beneficiary under this Article 7 shall extend for a period that begins on the date of the Qualifying Event and ends on the earliest of the following dates:

(a) The date on which the maximum period of coverage ends, which is:

(1) In the case of a Qualifying Event involving the termination or reduction of hours of a Participant's employment, the date which is eighteen (18) months after the date of the Qualifying Event; provided, however:

(A) If the Qualified Beneficiary is determined to have been disabled at any time during the first sixty (60) days of his or her continuation coverage under Title II or XVI of the Social Security Act and if the Qualified Beneficiary has timely notified the Plan Administrator of such determination in accordance with Section 7.7(c), the earlier of:

(i) the date that is twenty-nine (29) months after the date of the Qualifying Event; or

(ii) the first day of the month commencing more than thirty (30) days after a final determination that the Qualified Beneficiary is no longer disabled; or

(B) If any other Qualifying Event occurs during the eighteen (18) month period, (other than a bankruptcy proceeding described in Section 7.2(b)(6)) the date shall be extended to the date that is thirty-six (36) months after the date of the termination or reduction of hours; or

(2) In the case of any other Qualifying Event, the date that is thirty-six (36) months after the date of the Qualifying Event; or

(b) The date on which the Employer ceases to provide any group health plan to any employee; or

(c) If a premium is unpaid when due, the date that is thirty (30) days after the first day of the month on which a premium is due under a Health Care Plan or, if later, the date on which Participants would lose their coverage under the Health Care Plan due to failure to pay premiums when due; or

(d) The date on which the Qualified Beneficiary first becomes, after the date of the election, entitled to benefits under Medicare; or

(e) The date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or otherwise provided, however, if such other group health plan contains a limitation or exclusion with respect to any pre-existing condition of the person, continuation of coverage may

continue until the date such limitation or exclusion ends. The other group health plan will be the primary plan for all health services except those which are subject to the pre-existing condition limitation or exclusion.

7.4 Coverage Identical to Similarly Situated Employees. The continuation coverage will consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under a health care plan to similarly situated beneficiaries under a health care plan with respect to whom a Qualifying Event has not occurred. If coverage under a health care plan is modified for any group of similarly situated beneficiaries, coverage will be modified in the same manner for the Qualified Beneficiaries.

7.5 Premium. The Qualified Beneficiary must pay premiums for any period of continuation coverage.

(a) Such premiums shall not exceed one hundred two percent (102%) of the applicable premium as determined under and in accordance with Section 604 of ERISA.

(b) Notwithstanding Section 7.5(a), in the case of a qualified beneficiary who seeks an eleven-month (11-month) extension due to disability pursuant to Section 7.3(a)(1)(A), the premium may equal an amount up to one hundred fifty percent (150%) of the applicable premium.

(c) The premiums shall be paid in monthly installments payable on the first day of every month. However, if an election to continue coverage is timely made after the Qualifying Event, the Qualified Beneficiary may pay any premiums due for the period of continuation coverage which occurs prior to the date of the election within forty-five (45) days after the date of the election.

7.6 No Evidence of Insurability Required. The continuation coverage provided for in this Article 7 will not be conditioned upon or discriminate on the basis of lack of evidence of insurability.

7.7 Notice Requirements. The Sponsor, Plan Administrator, and Qualified Beneficiary are required to provide the following notifications:

(a) The Sponsor shall notify the Plan Administrator of any Qualifying Event involving the death of the Participant, such Participant's termination or reduction in hours, the Participant’s entitlement to Medicare benefits, or of the Employer's bankruptcy within thirty (30) days after the date of the Qualifying Event.

(b) The Qualified Beneficiary shall notify the Plan Administrator of the occurrence of a Qualifying Event involving the divorce or separation of a Participant or the loss of a Participant’s dependent’s status as a dependent within sixty (60) days after the date of such Qualifying Event. If the Qualified Beneficiary fails to notify the Plan Administrator of such a Qualifying Event within sixty (60) days, the Qualified Beneficiary shall forfeit his or her right to elect continuation coverage under this Article 7.

(c) Any Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled during the first sixty (60) days following the date of the Qualifying Event shall so notify the Plan Administrator within sixty (60) days of such determination; provided that such notice must occur in any event before the expiration of the initial eighteen-month (18-month) period following the Qualifying Event. In addition, the Qualified Beneficiary shall notify the Plan Administrator within thirty (30) days of any final determination that he or she is no longer disabled.

(d) Within fourteen (14) days after the Plan Administrator is notified of a Qualifying Event, the Plan Administrator shall notify any Qualified Beneficiary of his or her rights under this Article 7, provided that notice to a Qualified Beneficiary who is the spouse or former spouse of a Participant will be treated as notice to all other Qualified Beneficiaries residing with such spouse at the time such notice is given.

(e) Within fourteen (14) days after the Plan Administrator receives notice of a purported Qualifying Event with respect to which the individual is not entitled to continuation coverage, the Plan Administrator shall provide to such an individual an explanation as to why the individual is not entitled to continuation coverage.

(f) As soon as practicable after the Plan Administrator's determination that a Qualified Beneficiary's continuation coverage shall be terminated earlier than the maximum period of continuation coverage applicable to such Qualified Beneficiary, the Plan Administrator shall notify such Qualified Beneficiary of such termination. The Plan Administrator's notice shall include the reason for the termination of coverage, the date of termination of coverage, and any rights the qualified beneficiary may have under the Plan or applicable law to elect an alternative group or individual coverage, such as a conversion right.

7.8 Applicable Election Period. Any Qualified Beneficiary who elects continuation coverage under this Article 7 must make an election respecting such coverage during the applicable "election period." The Qualified Beneficiary's election period will begin on the date coverage would otherwise terminate under a health care plan by reason of a Qualifying Event, and will end sixty (60) days after the date coverage would otherwise terminate under a health care plan by reason of that Qualifying Event or sixty (60) days after the date the Qualified Beneficiary receives notice of his or her right to elect continuation coverage, whichever is later. Unless specified otherwise in an election, any election by a Participant or his or her spouse respecting continuation of coverage shall be deemed to include an election of continuation coverage on behalf of any other Qualified Beneficiary who would otherwise lose coverage under a Health Care Plan by reason of the same Qualifying Event.

7.9 Special Rules Relating to Continuation Coverage under Health Care Accounts. The following special rules shall apply to Participants who are Qualified Beneficiaries under a health flexible spending arrangement. Except as provided in this Section 7.9, the provisions of Sections 7.1 through 7.8 shall apply to such Participants.

(a) Notwithstanding the provisions of Section 7.2(a), a Qualified Beneficiary who would otherwise lose coverage under the health flexible spending arrangement as a result of a Qualifying Event shall be entitled to elect continuation coverage only if the amount of reimbursements for eligible health care expenses that could be paid for the remainder of the year equals or exceeds the amount of required payments for the remainder of the year.

(b) Notwithstanding the provisions of Section 7.3, continuation of coverage offered to any Qualified Beneficiary under the health flexible spending arrangement shall extend for a period that begins on the date of the Qualifying Event and ends on the last day of the health flexible spending arrangement's plan year.

ARTICLE 8 AMENDMENT OR TERMINATION OF PLAN

8.1 Amendment and Termination of Plan.

(a) Amendment.

(1) The Plan Sponsor reserves the right to amend this Plan from time to time. The Plan Sponsor may give continuing authority to amend the Plan to its officers or to a committee or committees designated by the Plan Sponsor's board of directors. Amendments to the Plan shall be in writing executed by the proper officers of the Plan Sponsor or by the chairperson of the committee empowered to amend the Plan.

(2) The Plan Sponsor reserves the right to amend, modify, or terminate all or any portion of the coverage under this Plan at any time on a prospective basis, any such action being within its complete and sole discretion.

(b) Termination. The Plan Sponsor reserves the right to terminate all or any portion of the Plan at any time, any such action being within its complete and sole discretion. The officers of the Plan Sponsor shall evidence the termination by executing appropriate documents and shall notify the Participants of the termination.

ARTICLE 9 MISCELLANEOUS PROVISIONS

9.1 Information to be Furnished. Participants shall provide their employers and the Plan Administrator with such information and evidence and shall sign such documents as may reasonably be requested from time to time for the purpose of administering the Plan.

9.2 No Guarantee of Employment. Participation in the Plan shall not be construed as giving an employee any right to continue in the employ of the Plan Sponsor. Any Eligible Employee shall remain subject to discharge by the Plan Sponsor to the same extent had this instrument not been executed.

9.3 Limitation of Rights. Neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits will be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor or Plan Administrator or their respective officers and directors, as an employee or otherwise, except as provided herein, and in no event will the terms of employment or service of any Participant or Eligible Employee be modified or in any way affected hereby.

9.4 Severability. If any provision of this Plan is held invalid, unenforceable, or inconsistent with the requirements for a group health plan governed by Code Section 105 or 106, its invalidity, unenforceability, or inconsistency shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of this Plan.

9.5 Captions. The captions contained herein are provided for convenience of reference and shall not be treated as part of this Plan.

9.6 Construction of Terms. Words of gender shall include persons and entities of any gender, the plural shall include the singular, and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

9.7 Governing Law, Venue Selection. To the extent not pre-empted by federal law, this Plan shall be construed, administered, and enforced according to the laws of Illinois. Any action by any Participant or beneficiary relating to or arising under the Plan shall be brought and resolved only in the U.S. District Court for the Northern District of Illinois. The federal court shall have personal jurisdiction over any party to an action relating to or arising under the Plan.

9.8 Mental Health Parity. The requirements of ERISA Section 712 shall apply to the extent both (1) medical and surgical benefits and (2) mental health or substance use disorder benefits are provided under this Plan, a Component Plan, or a Summary Plan Description.

9.9 No Vested Right to Benefits. Notwithstanding anything in this Plan or any Component Plan to the contrary, no Employee shall have any vested right to continued benefits under the Plan.

9.10 Assignment of Benefits. A Participant's right to receive benefits hereunder is personal to that Participant and may not be assigned or be subject to anticipation, garnishment, attachment, execution, or levy of any kind. The Plan shall not be liable for the debts or obligations of a Participant, except for assignment of the right to receive benefits to a provider of services or supplies as specified in a Component Plan.

9.11 Right to Information and Fraudulent Claims.

(a) The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a covered person examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

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

IN WITNESS WHEREOF, Tandem HR, LLC has caused this instrument to be signed and delivered effective as of the 20th day of April, 2023.

Tandem HR, LLC

By: James McCoy

Title: VP of Brokerage

EXHIBIT A
Component Plans

Medical Coverage
Dental Coverage
Vision Coverage
Life Insurance Plan
Short-Term Disability Plan
Long-Term Disability Plan
Critical Illness Plan
Hospital Indemnity Plan
Accident Plan
Flexible Spending Account Plan